

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
16928					16940					
1. DECEASED-NAME (Type or print) Lewis Edward Adkins					2a. DATE OF DEATH Month Dec Day 8 Year 68			2b. HOUR 8:30 M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 6, 1891		6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Tenn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.				
10. CITY OR TOWN OF DEATH Parkton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Miller Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Own Farm.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md			13b. COUNTY Balto.		13c. CITY OR TOWN Parkton		13d. INSOC CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Miller Rd.	
14. FATHER'S NAME First Morgan Middle Adkins Last Clantis					15. MOTHER'S MAIDEN NAME, First Wright Middle Wright Last Wright					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. 404-28-4368		17. INFORMANT Mrs. Dottie Dell, Miller Rd, Parkton, Md. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the larynx 1619 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1618										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 4/7/65 , to 12/8/68 , that (I) (we) last saw the deceased alive on 12/7/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE A.M. France MD DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 12/8/68					
22d. PHYSICIAN'S NAME (Type) A.M. FRANCE M.D.					22e. ADDRESS PARKTON, Md.					
23a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL (Specify)		23b. DATE Dec. 11, 1968		23c. NAME OF CEMETERY OR CREMATORY Guthrie Highland		23d. LOCATION (City or Town) (County) (State) Guthrie, Todd Co. Ky.				
24. FUNERAL DIRECTOR James J. Hartenstein, New Freedom, Pa.					25a. REC'D BY REGISTRAR DEC 12 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

MEDICAL CERTIFICATION



[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16929

CERTIFICATE OF DEATH

16941

1. DECEASED NAME (Type or print) First Middle Last Archer A. Alexander			2a. DATE OF DEATH Month Day Year December 24, 1968			2b. HOUR 2:30 M	
3. SEX male		4. RACE white		5. DATE OF BIRTH April 13, 1904		6. AGE (In years last birthday) 64 YRS.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) clerk typist		12b. KIND OF BUSINESS OR INDUSTRY US Govt.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN White Marsh		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Box 1072 R F D		14. FATHER'S NAME First Middle Last John Alexander		15. MOTHER'S MAIDEN NAME First Middle Last Ella Kennedy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 705-055393		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right cardiac failure 492X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary emphysema DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 5371							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that he (this hospital) attended the deceased from Oct. 21, 1959 , to Dec. 24, 1968 , that he (we) last saw the deceased alive on Dec. 24, 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <i>Diomidis Pirovolidis</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-24-68	
22d. PHYSICIAN'S NAME (Type) Diomidis Pirovolidis, M.D.				22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 27, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cemetery		23d. LOCATION (City or Town) (County) (State) Bradshaw Balto Md	
24. FUNERAL DIRECTOR ADDRESS Howard K. McComas & Son, Abingdon, Md.				25a. REC'D BY REGISTRAR DATE DEC 30 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
1. DECEASED-NAME (Type & print) CHARLES EDGAR ALLERS						2a. DATE OF DEATH Dec. 25 1968			2b. HOUR 3:45 PM		
3. SEX MALE		4. RACE White		5. DATE OF BIRTH June 12, 1884		6. AGE (In years lost birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign) McDonough Ill. U.S.A.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Co. Md.			
10. CITY OR TOWN OF DEATH CATONSVILLE MD.				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUMMIT Nursing Home				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMER		12b. KIND OF BUSINESS OR INDUSTRY McDONOUGH SCH	
13a. USUAL RESIDENCE (Where deceased lived, if institution—Residence before admission) STATE MD.				13b. COUNTY Baltimore		13c. CITY OR TOWN Catonville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 11 Shenton Rd.	
14. FATHER'S NAME First Middle Last John Henry Allers				15. MOTHER'S MAIDEN NAME First Middle Last Lavinia Mulligan							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown None (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 212-16-8211		17. INFORMANT Mrs. Frances A. Seavitt Address 11 Shenton Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) 4129 DISEASE; CORONARY INSUFFICIENCY											
DUE TO, OR AS A CONSEQUENCE OF URINARY TRACT INFECTION											
(b) MULTIPLE DECUBITUS ULCERS											
DUE TO, OR AS A CONSEQUENCE OF ARTHRITIS DEFORMANS - VERY ADVANCED											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12/19 , 19 68 , to 12/25 , 19 68 , that (I) (we) lost the deceased alive on 12/23/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J. Keson M.D.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 12/25/68			
22d. PHYSICIAN'S NAME (Type) E. LASATI'S, M.D.				22e. ADDRESS 1801 FREDERICK ST. BALTIMORE, MD 21228							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE Dec. 28, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Lawrence Cemetery		23d. LOCATION (City or Town) (County) (State) Pikesville Baltimore MD			
24. FUNERAL DIRECTOR Frank A. Newell				ADDRESS Pikesville, Md.				25. RECEIVED BY REGISTRAR DEC 26 1968			
								25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16931

CERTIFICATE OF DEATH

16943

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month 9, Day 9, 1968		2b. HOUR 5:15 AM	
PAULINE		N.		ALT				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH OCTOBER 14, 1897		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE,		Md.
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN TOWSON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 610 GOUCHER BLVD. #21204
14. FATHER'S NAME First Middle Last Dimitri Nikitenko		15. MOTHER'S MAIDEN NAME First Middle Last Anna Petroff						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) none		17. INFORMANT Family records		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach with metastasis. 151.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 151X								
19a. DATE OF OPERATION 11-26-68 12-2-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Esophageal obstruction. Ca. of stomach with metastasis.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from November 24, 1968, to December 9, 1968, that (X) (we) lost saw the deceased alive on December 9, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Camilo Z Tomboc				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED December 9, 1968		
22d. PHYSICIAN'S NAME (Type) Camilo Tomboc, M.D.				22e. ADDRESS 7620 York Road Towson, Md. #21204				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Burial-transit 12/11/68		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Park		23d. LOCATION (City or Town) (County) (State) West Palm Beach Florida		
24. FUNERAL DIRECTOR ADDRESS John Burns Sons 610-12 York Rd. Towson, Md.				25a. REC'D BY REGISTRAR DA DEC 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

5022.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

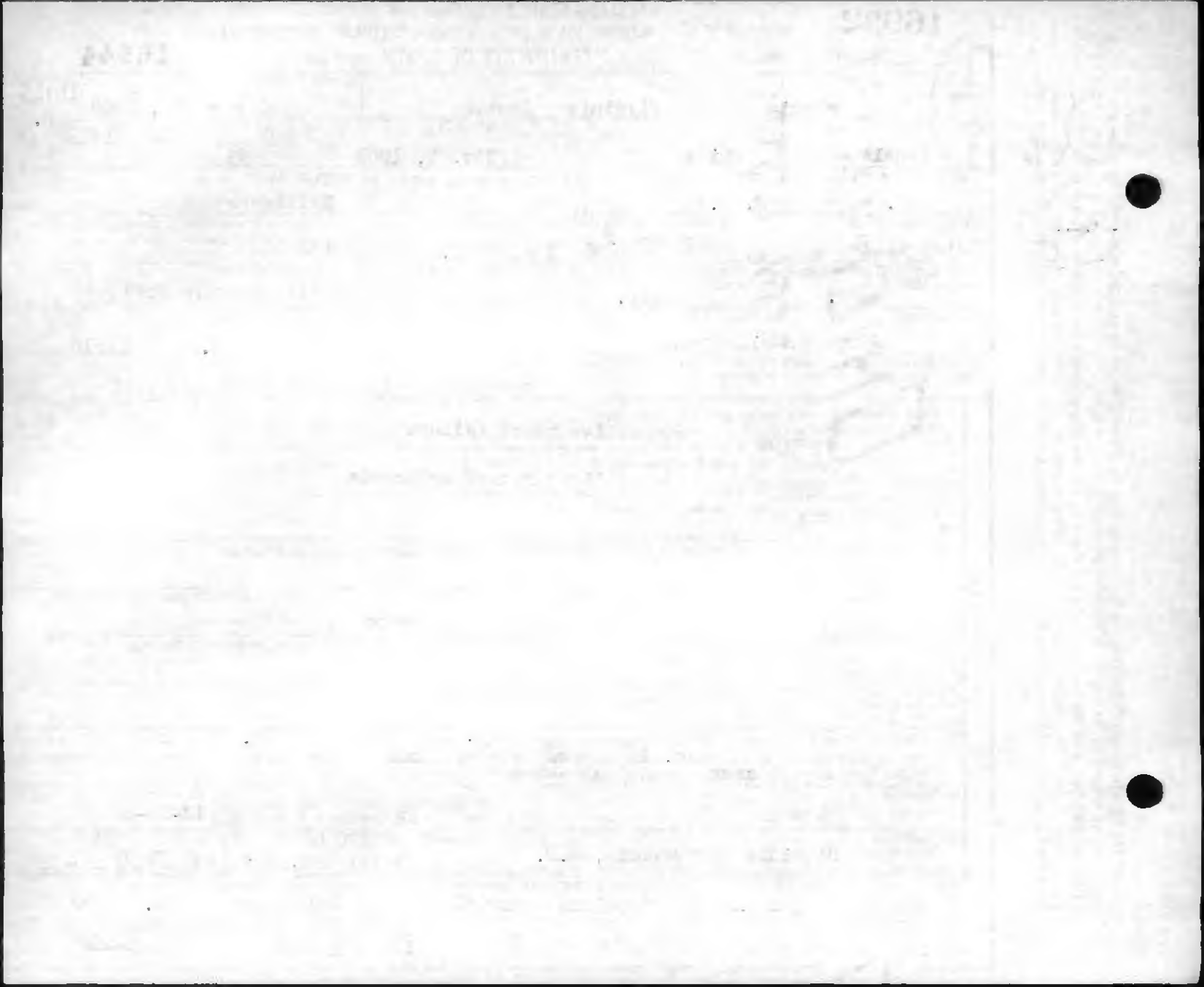
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VR A15
304 REV. 1-68

16932										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 1 Film 6407 12/23/68 kk										CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH									
First Middle Last Minnie Virginia Austin Austen										Month Day Year December 15, 1968									
3. SEX female										4. RACE white									
5. DATE OF BIRTH Nov. 9, 1909										6. AGE (In years lost birthday) 59 YRS.									
7a. BIRTHPLACE (State or foreign country) Md.										7b. CITIZEN OF WHAT COUNTRY? U. S.									
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Baltimore Md.									
10. CITY OR TOWN OF DEATH Catonsville										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.									
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife										12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.										13b. COUNTY Balto.									
13c. CITY OR TOWN Covans										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>									
13e. STREET AND NUMBER 612 Anneslie Road																			
14. FATHER'S NAME First Middle Last Benjamin Wilkinson										15. MOTHER'S MAIDEN NAME First Middle Last Dora V. Earle									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No										16b. SOCIAL SECURITY NO. (If yes give war or dates of service)									
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL										Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4500										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)									
21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 22, 1968</u> , to <u>Dec. 15, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec. 15, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																			
22b. SIGNATURE <u>Diomidis Pirovolidis</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 12-16-68									
22d. PHYSICIAN'S NAME (Type) Diomidis Pirovolidis, M.D.										22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 12-19-1968									
23c. NAME OF CEMETERY OR CREMATORY Moreland emorial										23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md									
24. FUNERAL DIRECTOR, Lassahn Funeral Home 7401 Elair Road 21236										25a. REC'D BY REGISTRAR DATE <u>DEC 23 1968</u>									
										25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>									

MEDICAL CERTIFICATION

20271



TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 405 (4)
JAN 17 1968

16923

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16945

1. DECEASED-NAME (Type or print)		First JOHN	Middle NMN	Last BACON	2a. DATE OF DEATH 12 Month 31 Day 68 Year		2b. HOUR a 2:10 M	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH 3-6-1893		6. AGE (In years lost birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Ireland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md		
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GTR. BALTO. MED. CENTER		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Chemical Analyst-ret.		12b. KIND OF BUSINESS OR INDUSTRY Wylie Chem. Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Cockeysville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Falls Road
14. FATHER'S NAME First Middle Last Robert Bacon				15. MOTHER'S MAIDEN NAME First Middle Last Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) <input checked="" type="checkbox"/> No		16b. SOCIAL SECURITY NO (If yes give year or dates of service) None		17. INFORMANT Address Family records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO-SCLEROTIC CARDIO VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4221 METASTATIC CA OF PROSTATE								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that he (this hospital) attended the deceased from 11-30 , 19 68 , to 12-31 , 19 68 , that he (we) last saw the deceased alive on 12-31 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Josefino C. Aguilar MD				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-31-68		
22d. PHYSICIAN'S NAME (Type) DR. JOSEFINO C. AGUILAR				22e. ADDRESS 6701 N. CHARLES ST.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 2, 1969		23c. NAME OF CEMETERY OR CREMATORY Jesson's Cemetery		23d. LOCAT ON (City or Town) (County) (State) Cockeysville, Md		
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland				25a. REC'D BY REGISTRAR DATE JAN 6 1969		25b. REGISTRAR'S SIGNATURE f Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16934

CERTIFICATE OF DEATH

16946

1. DECEASED NAME (Type or print) HERMAN		First	Middle	Last	2a. DATE OF DEATH Month 12 Day 24 Year 68		2b. HOUR 5:50 P.M.	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 2-4-1883			6. AGE (In years last birthday) 85 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0
7a. BIRTHPLACE (State or foreign country) BALTO.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE				
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hospital			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE	13c. CITY OR TOWN PARKVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 9100 Smith Avenue			
14. FATHER'S NAME First RUDOLPH Middle BARK Last			15. MOTHER'S MAIDEN NAME First ULMAN Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 420-34-7179		17. INFORMANT MRS. HERMAN BARK 9100 SMITH AVE.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease; Cong. Heart Failure 4129 DUE TO, OR AS A CONSEQUENCE OF (b) Uremia DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4300								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour 19 Month 12 Day 24 Year 68 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 12-24- , 19 68 , to 12-24- , 19 68 , that (I) (we) last saw the deceased alive on 12-24- , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Julia C. Baldonado				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS 7620 York Road, Towson, Md. 21204				
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12-28-68		23c. NAME OF CEMETERY OR CREMATORY Belair Mem. Cem.		23d. LOCATION (City or Town) (County) (State) Belair Md.		
24. FUNERAL DIRECTOR Lessahy FH 7401 Belair Rd.				25a. REC'D BY REGISTRAR DATE DEC 30 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-69

16935

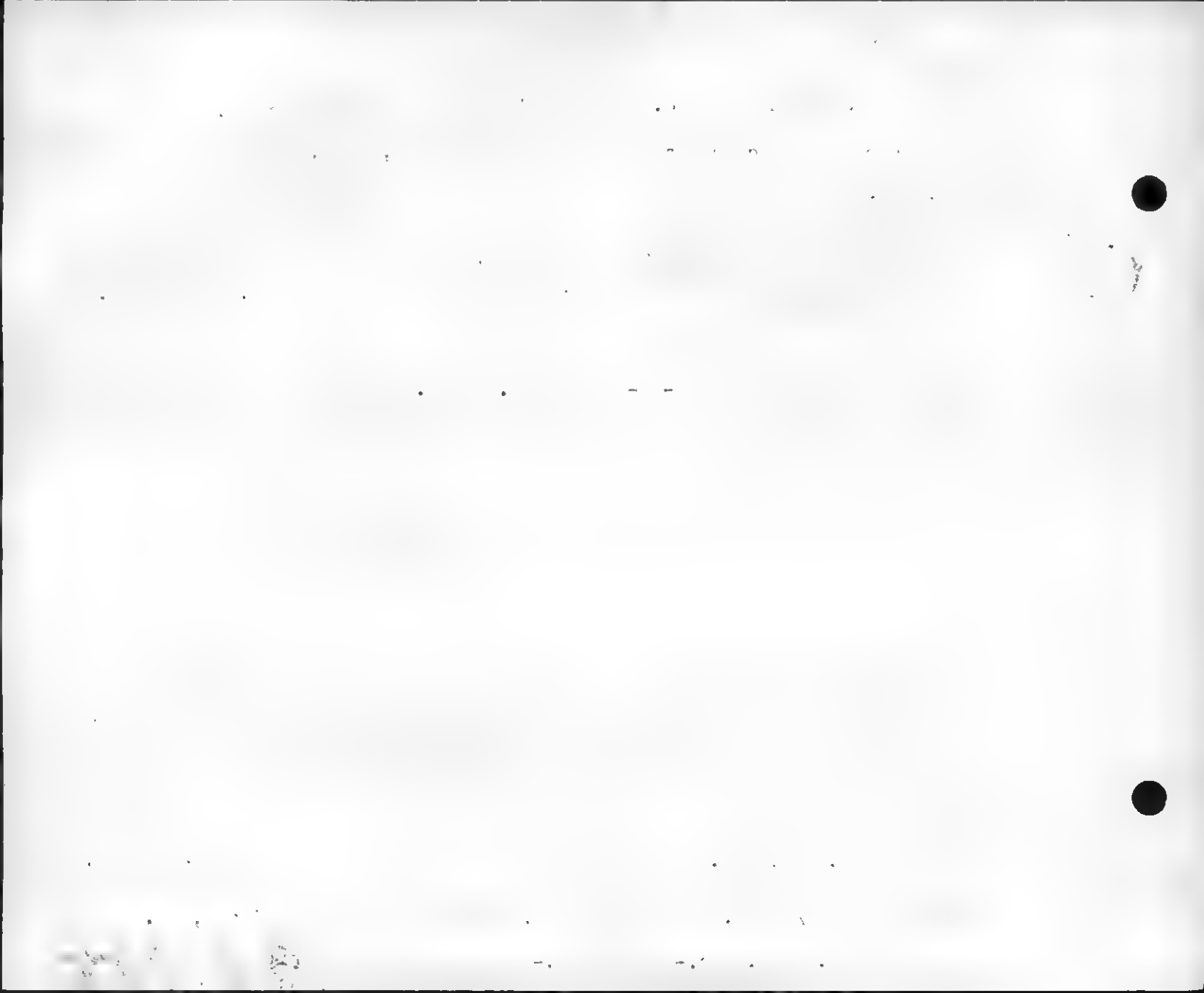
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16947

1 DECEASED-NAME (Type or print) WILLIAM J. BATCHLER			2a DATE OF DEATH Month December Day 17 Year 1968			2b HOUR M				
3 SEX male		4 RACE caucasian		5 DATE OF BIRTH December 27, 1889.		6 AGE (In years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.				
10. CITY OR TOWN OF DEATH Towson			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chesapeake Manor Nurs. Home			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Electrical Contractor			12b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 4516 N. Charles St.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) No (If yes give war or dates of service)			16b SOCIAL SECURITY NO 041-05-7836		17 INFORMANT Mrs. Flo B. Batchler			Address (Same)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral & Pulmonary 2 Metastases 185 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6-7 months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1. Arteriosclerotic Heart Disease. Chronic Failure										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State				
22a I certify that (I) (this hospital) attended the deceased from Nov , 19 52 , to 12/17 , 19 68 , that (I) (we) last saw the deceased alive on 12/14 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Sylvan D. Goldberg, M.D.						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 12/18/68		
22d. PHYSICIAN'S NAME (Type) Dr. Sylvan D. Goldberg						22e ADDRESS Medical Arts Bldg, Balto, Md.				
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE 12/20/68.		23c NAME OF CEMETERY OR CREMATORY Lorraine Pk. Mausoleum		23d LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. - Balto, Md. - 14						25a REC'D BY REGISTRAR DATE DEC 18 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge		

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16976

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16948

1. DECEASED-NAME (Type or Print) FREDERICK C. BAUER			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 2b. HOUR <input type="checkbox"/>		
3. SEX M	4. RACE W	5. DATE OF BIRTH 5/24/02	6. AGE (in years last birthday) 66 YRS	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH ESSEX		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1420 SHORE RD. KENILWORTH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HEATING	
13a. USUAL RESIDENCE (Where deceased lived, if not on Residence before admission) STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN ESSEX	
14. FATHER'S NAME First ? Middle ? Last ?		15. MOTHER'S MAIDEN NAME First ? Middle ? Last ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16b. SOCIAL SECURITY NO 212-03-4651		17. INFORMANT ALMA BAUER		ADDRESS ABOVE	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: 41 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF HCUP (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION 4/10/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? HEART		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No _____ City or Town _____ County _____ State _____	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Theresa C. Altman		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 12/19/68	
EXAMINER'S NAME (Type) THESA, C. ALTMAN		ASS STANT MED. CAL. EXAMINER <input type="checkbox"/>		DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12/19/68		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN	
24. FUNERAL DIRECTOR J.E. CONNELLY SONS		ADDRESS 300 MACE		25a. REC'D BY REGISTRAR DEC 19 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

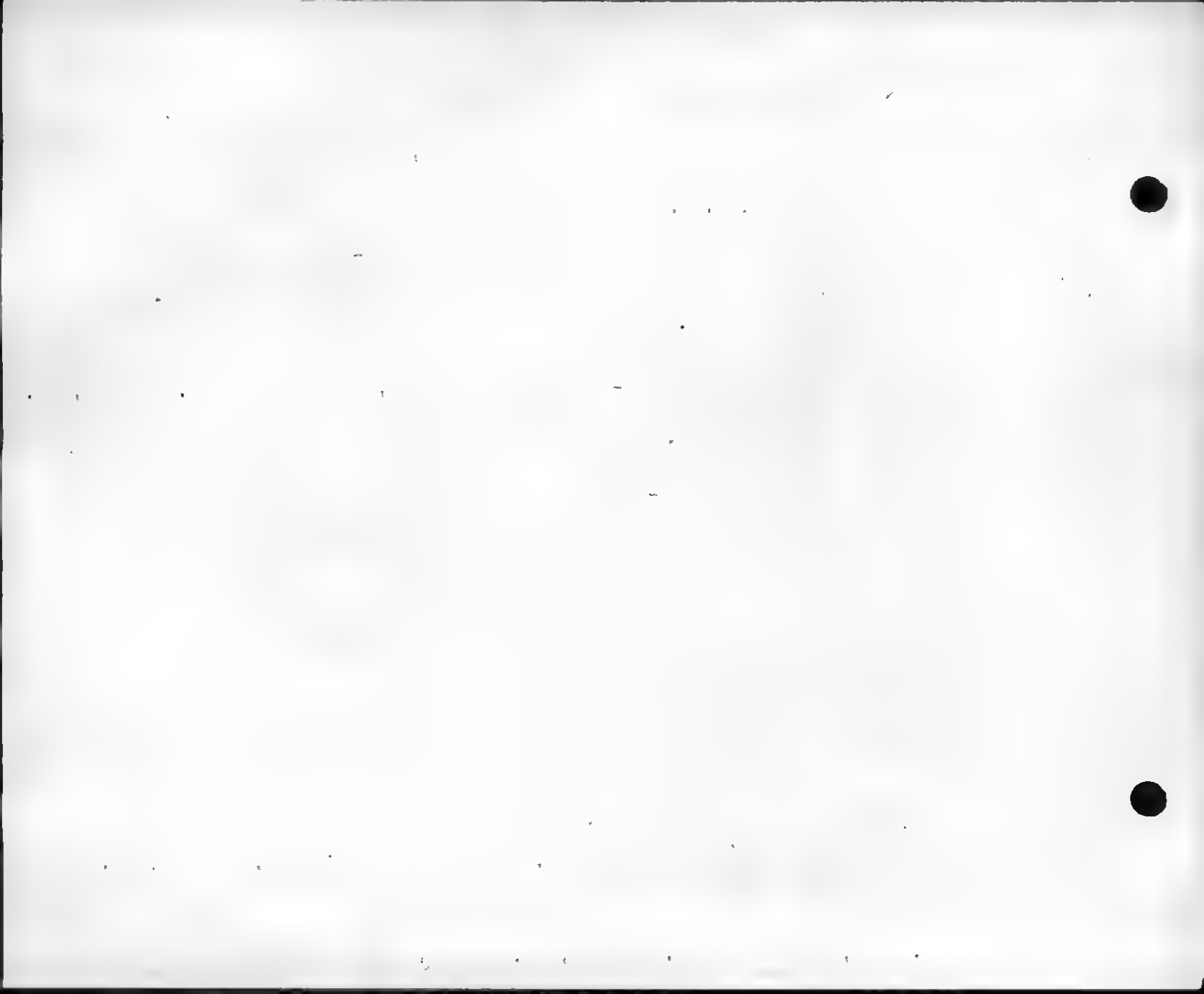


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)		First Joseph (Guilsieppe)		Middle		Last Bavota		2a DATE OF DEATH Month Day Year December 31, 1968			2b HOUR M
3 SEX Male		4 RACE White		5 DATE OF BIRTH April 16, 1877			6 AGE (in years last birthday) 91 YRS		FUNKER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) Italy		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.					
10 CITY OR TOWN OF DEATH Dundalk		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 851 Jaydee Avenue		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Self-employed Shoemaker			12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Dundalk		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 851 Jaydee Ave.			
14 FATHER'S NAME First Middle Last Joseph Bavota				15 MOTHER'S MAIDEN NAME First Middle Last ??							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown No		16b SOCIAL SECURITY NO (If yes give war or dates of service) 217-16-6170		17 INFORMANT (Son) Address Roland Bavota, 206 Parkwood Rd. Dundalk, Md.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 years</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>4109</u>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a I certify that (I) (this hospital) attended the deceased from <u>8/1/60</u> , 19 <u>60</u> , to <u>12/30</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/30</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d/d) (did not) view the body after death <u>Dec 31-1968-2 PM</u>											
22b SIGNATURE <u>Morris A. Jacobs M.D.</u>		22c ADDRESS M.D. 1010 North Point Rd. Dundalk, Md.		22d PHYSICIAN'S NAME (Type) Morris Jacobs		22e ADDRESS M.D. 1010 North Point Rd. Dundalk, Md.		22f DATE SIGNED 1/2/69			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 1/4/69		23c NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24 FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				25a REC'D BY REGISTRAR DATE JAN 6 1969		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

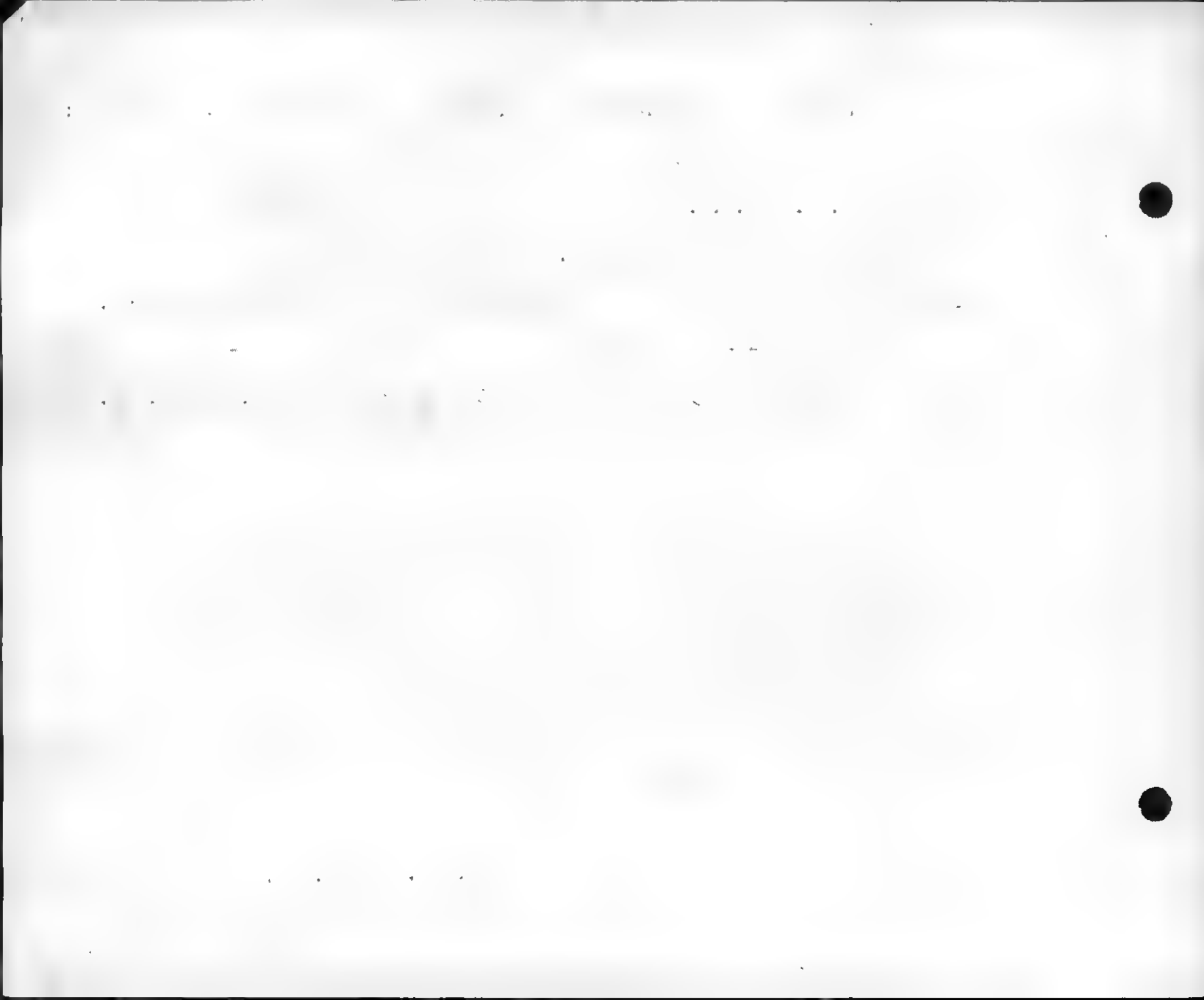
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16928

CERTIFICATE OF DEATH

16950

1 DECEASED NAME (Type or print) First Middle Last JAMES FREDERICK BAZEMORE			2a DATE OF DEATH Month Day Year DECEMBER 23, 1968		2b HOUR 4:30p	
3 SEX MALE		4 RACE NEGRO		5 DATE OF BIRTH 2/10/23		6 AGE (In years last birthday) 45 YRS
7a BIRTHPLACE (State or foreign country) WASHINGTON, D. C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE,
10 CITY OR TOWN OF DEATH FORT HOWARD		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMIN. HOSPITAL		12a U.S.A. OCCUPATION (Kind of work done during past 12 months, even if retired) MAINTENANCE		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE MARYLAND		13b COUNTY BALTIMORE		13c CITY OR TOWN BALTIMORE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e STREET AND NUMBER 1419 CHESAPEAKE CT.		14 FATHER'S NAME First Middle Last REFUS - - BAZEMORE		15 MOTHER'S MAIDEN NAME First Middle Last ETHEL - - HOLMES		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES		16b SOCIAL SECURITY NO WWII 579 18 10 98		17 INFORMANT Address CLINICAL RECORDS, VAH, FT. HOWARD, MD.		
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) GASTROINTESTINAL HEMORRHAGE 5679 DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE RENAL FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 578x DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) BRONCHOPNEUMONIA						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no autopsy
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)		
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC.)		21f LOCATION Street or RFD No City or Town County State		
22a I certify that to (this hospital) attended the deceased from DEC 13 , 19 68 , to DEC 23 , 19 68 , that to (we) last saw the deceased alive on DEC 23 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) not view the body after death						
22b SIGNATURE J. D. Talbert M.D.						22c DATE SIGNED 12/24/68
22d PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		22e ADDRESS VAH, FT. HOWARD, MD.				
23a BURIAL, CREMATION, or other disposition BURIAL		23b DATE 12-28-68		23c NAME OF CEMETERY OR CREMATORY Harmony Cemetery		23d LOCATION (City or Town) (County) (State) Prince Georges, Md.
24. FUNERAL DIRECTOR Philip X. Kay		ADDRESS BARNES AND MATTHEWS		25a RECORDING OFFICE DEC 20, 1968		
		3619 14th St. N.W.		Baltimore, Md.		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
30M REV 11-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) HARRY			First Middle Last Beefelt			2a. DATE OF DEATH Month 12 Day 3 Year 68			2b. HOUR 11 P.
3 SEX male		4 RACE White		5 DATE OF BIRTH April 11, 1881			6 AGE (In years lost birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a BIRTHPLACE (State or foreign country) Baltimore		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.			
10 CITY OR TOWN OF DEATH Fullerton Baltimore		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7800 Rolling View Ave			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FARMER			12b. KIND OF BUSINESS OR INDUSTRY FARM WORK	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MD.		13b COUNTY BALTO.		13c CITY OR TOWN Fullerton		13d INSIDE CITY - IN 157 YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 7800 Rolling View Ave.	
14 FATHER'S NAME First Middle Last UNKNOWN				15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No				16b SOCIAL SECURITY NO —		17. INFORMANT Ross Fitch Address 7800 Rolling View Ave BALTO.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Lung 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 163x Arteriosclerosis, generalized									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July 18, 1967 , to Dec. 3, 1968 , that (I) (we) lost saw the deceased alive on Nov. 22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE Adam G Swiss M.D.		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED Dec. 4, 1968			
22d. PHYSICIAN'S NAME (Type) Adam G Swiss		22e. ADDRESS 6232 Belair Rd. Balto., Md 21206							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12/6/68		23c. NAME OF CEMETERY OR CREMATORY St. John's		23d. LOCATION (City or Town) (County) (State) Parkville, Balt			
24. FUNERAL DIRECTOR Lassala Funeral Home		ADDRESS 7401 Belair Rd Balto 36		25a. REC'D BY REGISTRAR DATE DEC 6 1968		25b. REGISTRAR'S SIGNATURE Charles J. Jones			

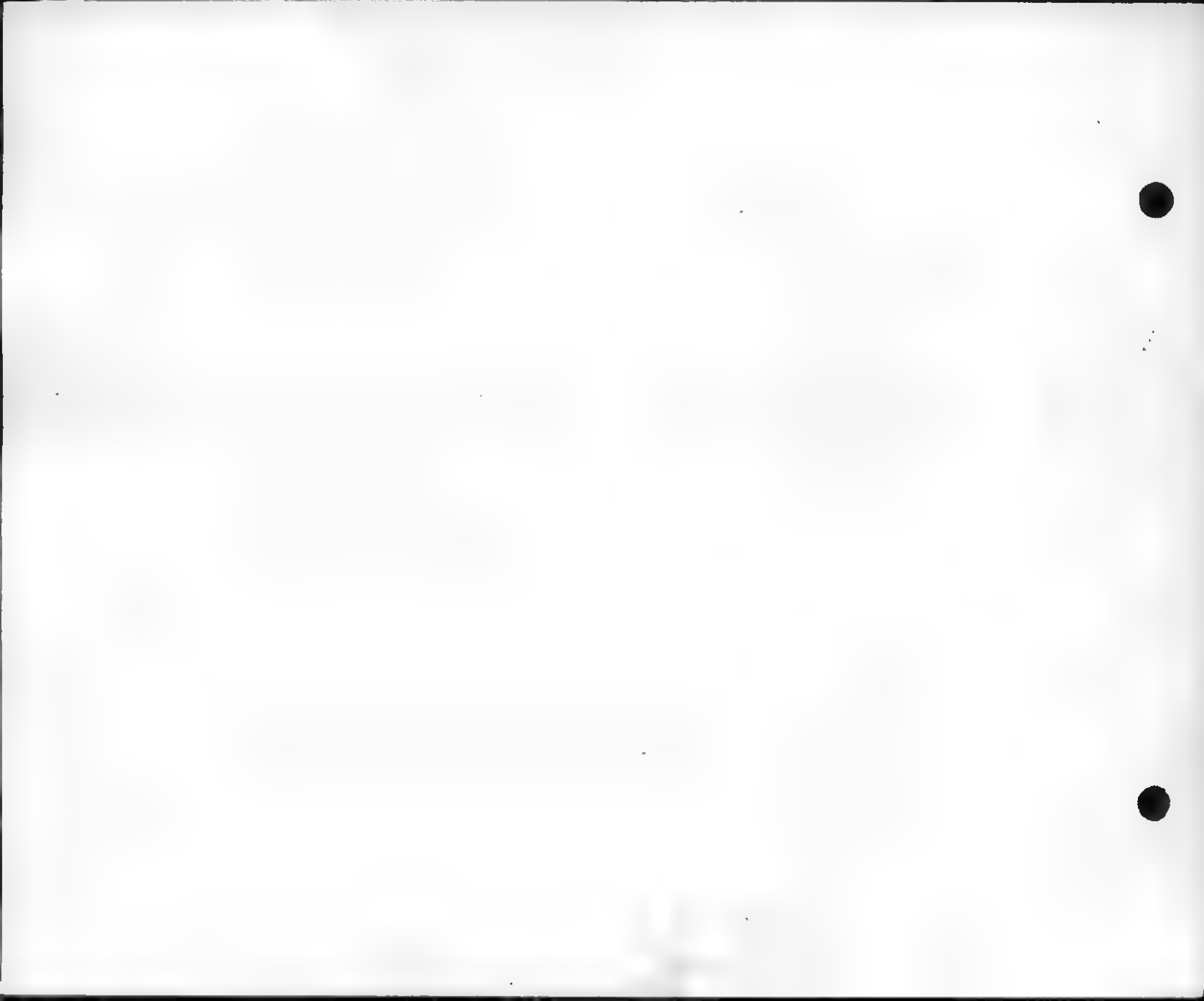
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the card headers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16940										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16952																													
1 DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
GEORGE										Month 12 Day 17 Year 68										12:00 PM																													
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										7. UNDER 24 HRS									
MALE										NEGRO										3/6/96										72 YRS										MONTHS DAYS HOURS MIN									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED										9. COUNTY OF DEATH										10. KIND OF BUSINESS OR INDUSTRY									
NORTH CAROLINA										U.S.A.										WIDOWED										BALTIMORE COUNTY, Md.										SELF EMPLOYED									
11. CITY OR TOWN OF DEATH										12. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										13. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										14. KIND OF BUSINESS OR INDUSTRY																			
FORT HOWARD										VET. ADM. HOSP. FT HOWARD, MD.										PAINTER										SELF EMPLOYED																			
15a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE										15b. CITY OR TOWN										15c. INSIDE CITY LIMITS?										15d. STREET AND NUMBER																			
MARYLAND										WICOMICO										YES										102 SECOND STREET																			
16. FATHER'S NAME										17. MOTHER'S MARDEN NAME										18. INFORMANT										19. ADDRESS																			
ALFRED										HETTIE DAVIS										CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)										16b. SOCIAL SECURITY NO										17. INFORMANT										19. ADDRESS																			
YES										216 14 20 79										CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.																													
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))										19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a)										RECENT										RECENT																			
4										BRONCHOPNEUMONIA																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b)										RECENT										RECENT																			
										PULMONARY CONGESTION AND EDEMA																																							
										(c)										RECENT										RECENT																			
										DIFFUSE CEREBRAL EDEMA																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																																																	
334x																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
																				YES										YES																			
21a. ACCIDENT WAS UNDERLYING										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED										21d. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)										HOUR A.M. Month Day Year P.M. 19										Enter nature of injury in Part I or Part 2, Item 18)																													
21d. INJURY OCCURRED										21e. PLACE OF INJURY										21f. LOCATION										21g. CITY OR TOWN																			
While at work										(AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC										Street or R.F.D. No										County																			
22a. I certify that (1) (this hospital) attended the deceased from 12/13/68, 19 to 12/17/1968, 19, that (2) (we) last saw the deceased alive on 12/17/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (3) (we) (did) (do not) view the body after death.																																																	
22b. SIGNATURE										22c. DATE SIGNED										22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
Peter Juvan										12/17/68										PETER V. JUVAN, M. D.										VAH FORT HOWARD, MARYLAND																			
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																			
BURIAL										12/22/68										GREEN ACRES CEMETERY										SALISBURY, MARYLAND																			
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE										25c. DATE																			
Clinton F. Stewart										DEC 23 1968										f. Charles Judge																													
SALISBURY, MARYLAND																																																	

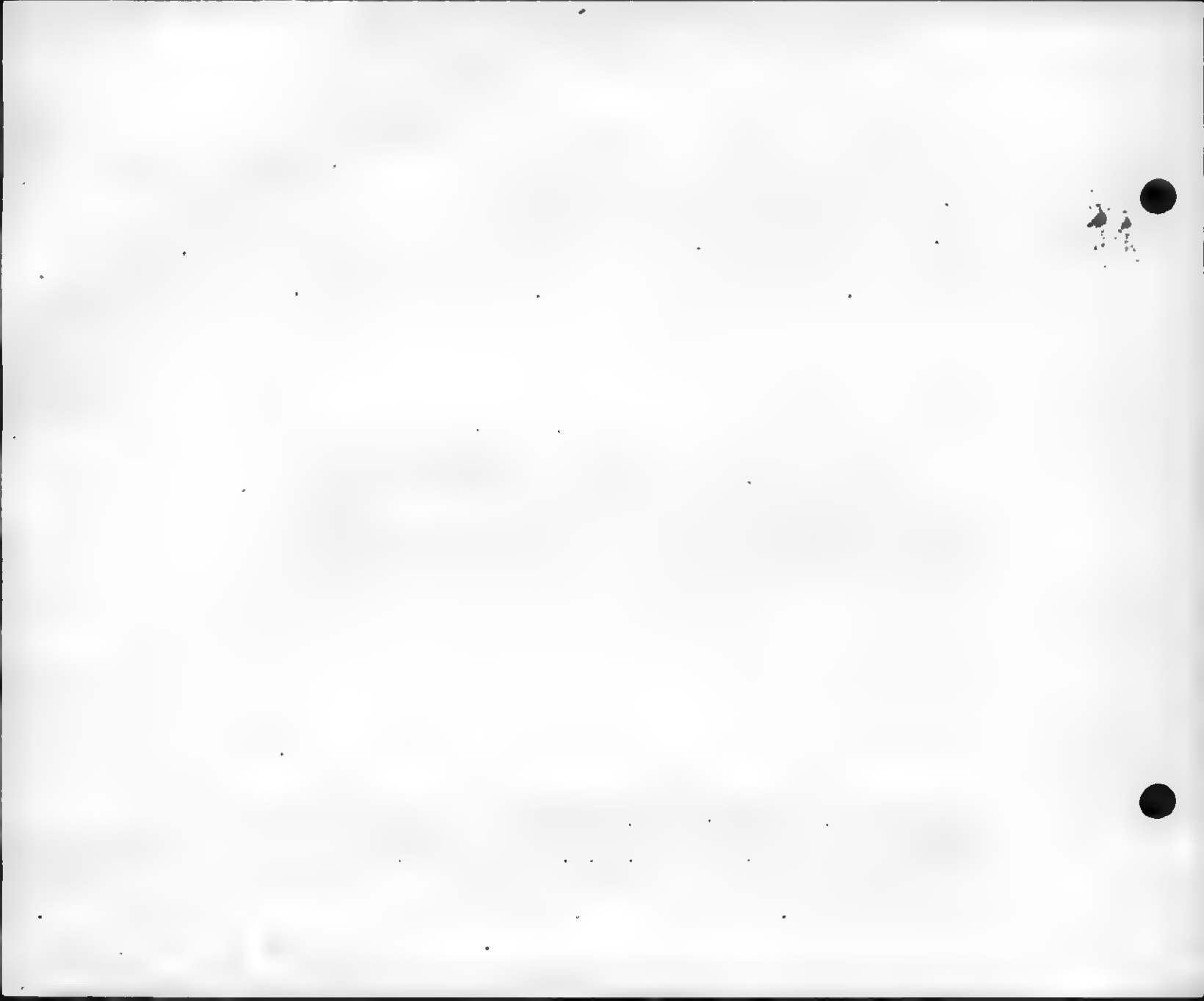


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or Print)			First		Middle		Last			2a DATE KNOWN OF DEATH		2b HOUR	
James			N		Bennett					Month 12 Day 21 Year 1968		12:45 PM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR			
M	W	12/27/13	54 YRS	MONTHS DAYS		HOURS MIN		Month 12 Day 21 Year 1968		p		M	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
W. Virginia			USA						Baltimore County Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b KIND OF BUSINESS OR INDUSTRY				
Baltimore County			Baltimore County General			Maintenance mech.			Schenuit				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET AND NUMBER	
Md.			Frederick			Mt. Airy			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. 1x 1 RubberCo.	
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES?			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS	
First Middle Last			First Middle Last			Yes, no, or unknown			(If yes give war or dates of service)			Mr. Teh w, 97 Ridge Ave.	
Urey			Bennett			Anthela			Hammond				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF			4109			Acute Coronary Occlusion or Arrhythmia			6 months			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			4201			Arteriosclerotic Cardiovascular Disease							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)			Slipped disc.										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 ADJUSTED?			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			J. Nelson McKay, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b DATE SIGNED			12/21/68	
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
Burial			Dec. 26, 1968			Mt. Olive			Tioga, Nicholas, W. Va.				
24 FUNERAL DIRECTOR			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE							
Edwin L. McLaughlin			DEC 27 1968			J. Charles Judge							
MORRIS North Funeral Home, Damascus, Md.													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115
30M REV. 5-58

16912

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16954

1. DECEASED NAME (Type or print) Jesse Lee Bennett, Jr.			2a. DATE OF DEATH Month 12 Day 2 Year 1968			2b. HOUR 12:54 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 9-21-1914		6. AGE (In years lost b. today) 54 YRS.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto.	
10. CITY OR TOWN OF DEATH Carney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 9233 Harford View Dr.		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. USUAL RESIDENCE (Where deceased lived, if institut on- Residence before admission) STATE M Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Carney		13d. INSIDE CITY LIM TSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 9233 Harford View		13f. DR. Dr.					
14. FATHER'S NAME First Middle Last Jesse Lee Bennett, Sr.			15. MOTHER'S MAIDEN NAME First Middle Last Anna Adlesberger				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 218-01-1399		17. INFORMANT Address Catherine W. Bennett Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 6 yrs. (b) Rheumatoid arthritis DUE TO, OR AS A CONSEQUENCE OF 20 yrs. (c) 20 yrs. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) None							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 men
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med cal examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (1) this hospital attended the deceased from July , 1956, to Dec 1 , 1968, that (1) we last saw the deceased alive on Nov 6 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (ad) (did not) view the body after death.							
22b. SIGNATURE George T. Gilmore, M.D.				22c. DATE SIGNED 12-2-1968		22d. ADDRESS Lanham Bldg., Lutherville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-4-1968		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.		23d. LOCATION (City or Town) (County) (State) Fullerton Balto. Md.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Inc. 1050 York Rd., Towson, Md.				25a. REC'D BY REGISTRAR DEC 5 1968		25b. REGISTRAR'S SIGNATURE William J. Young	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in (pages 1 and 2), director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. at Health pr. or to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16955												
Item 7 Film 08 1/3/69 kh												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print) Charles Bantz						2a DATE OF DEATH Month 12 Day 23 Year 68			2b HOUR 7 P. M.			
3. SEX Male		4 RACE White		5. DATE OF BIRTH Mar. 3, 1885			6. AGE (In years lost birthday) 83 YRS		IF UNDER YEAR MONTHS 9 DAYS 20		IF UNDER 24 HRS HOURS 7 MIN 00	
7a BIRTHPLACE (State or foreign country) Mo.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Balto.						
10 CITY OR TOWN OF DEATH Catonsville Md.			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Paradise Nursing Home.			12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Retired			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Mo.			13b. COUNTY Balto.			13c CITY OR TOWN Catonsville			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 921 Masefield Road
14 FATHER'S NAME First Middle Last George Bantz						15 MOTHER'S MAIDEN NAME First Middle Last Elizabeth Schultz						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown				16b SOCIAL SECURITY NO 215-07-5513		17. INFORMANT Mrs. Helen Address 921 Masefield Rd. Balto., Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) hypertension DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4200 psoriasis												
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 10 11:54 19 , to 12-23-68 , that (I) (we) last saw the deceased alive on 12-23-68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE HARRY S. GIMBEL						22c DATE SIGNED 12-24-68						
22d. PHYSICIAN'S NAME (Type) HARRY S. GIMBEL						22e ADDRESS 4605 Edmondson Ave						
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE 12/26/1968		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore Maryland						
24 FUNERAL DIRECTOR H. H. Witzke & Sons ADDRESS 4101 Edmondson Ave.						25a REC'D BY REGISTRAR DEC 27 1968		25b REGISTRAR'S SIGNATURE J. J. J.				

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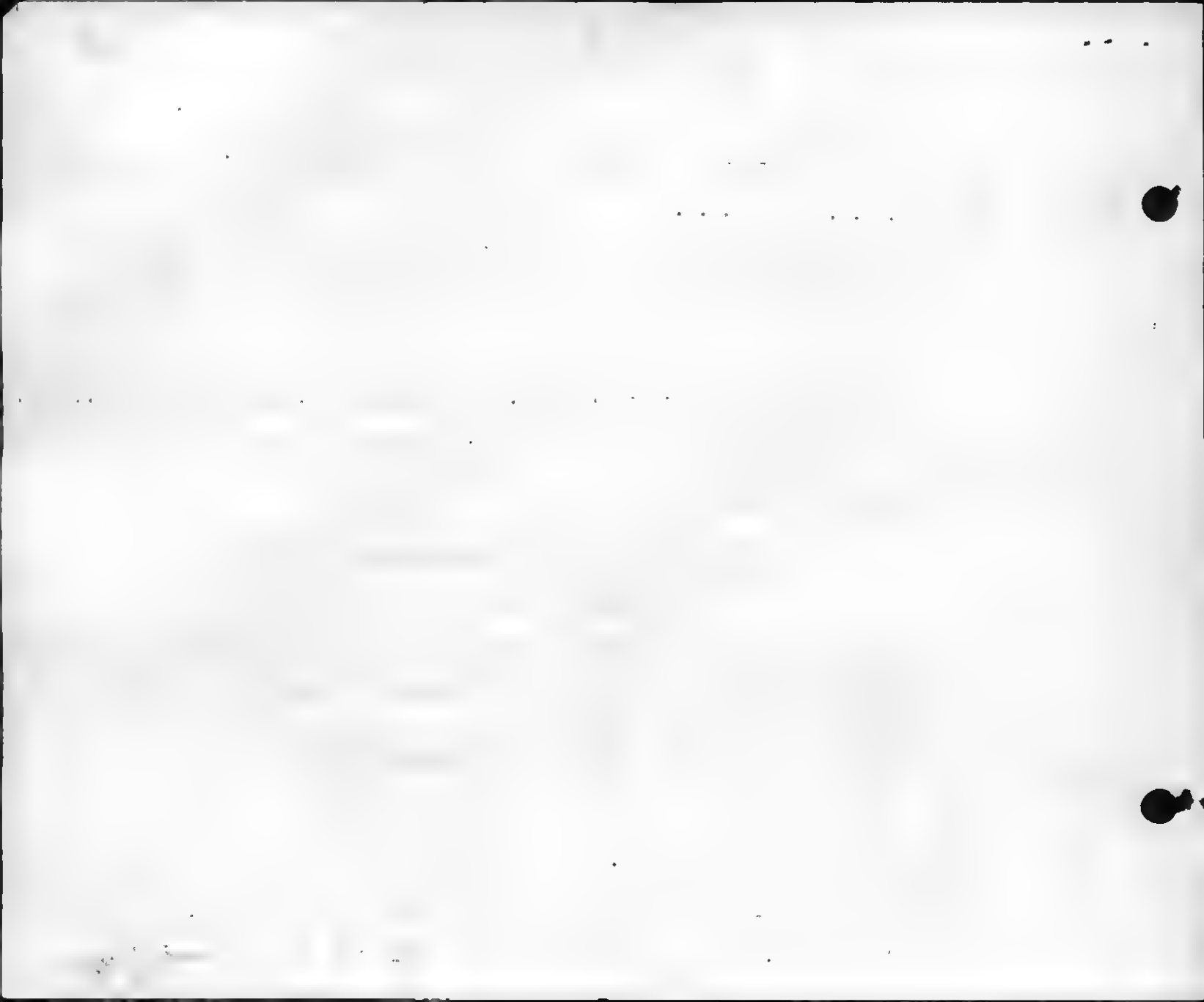


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> 16911 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16956 </div> <h2 style="text-align: center;">MEDICAL EXAMINER'S CERTIFICATE OF DEATH</h2>											
1 DECEASED NAME (Type or Print) THEODORE			First Middle Last			2a DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> Dec. 8, 1968			2b HOUR 1:08 A.M.		
3 SEX Male	4 RACE White	5 DATE OF BIRTH 8-17-1908	6 AGE (in years last birthday) 60 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Dec. Day 8, Year 1968			2d HOJR 1:08 A.M.		
7a BIRTHPLACE (State or foreign country) NEW YORK, N.Y.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			Md		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Korvette Store Parking Lot Rte 40 West		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) EMPLOYEE			12b. KIND OF BUSINESS OR INDUSTRY KORVETTE				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b COUNTY Baltimore		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 3703 Fallstaff Road		
14 FATHER'S NAME JACOB			First Middle Last			15. MOTHER'S MAIDEN NAME YETTA			First Middle Last ?		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b SOCIAL SECURITY NO (If yes give war or dates of service) 035-05-0113		17 INFORMANT ADDRESS MRS. MARTHA BERKOWITZ, 3703 FALLSTAFF RD., APT. C							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 41 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 7221											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Edward F. Wilson, M.D.		EXAMINER'S NAME (Type)		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 12-9-68		23c NAME OF CEMETERY OR CREMATORY OHR KNESSETH ISRAEL ANSHE SHARD, ROSEDALE, MARYLAND				23d LOCATION (City or Town) (County) (State)		22b DATE SIGNED December 8, 1968	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				ADDRESS		25a REC'D BY REGISTRAR DATE DEC 10 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

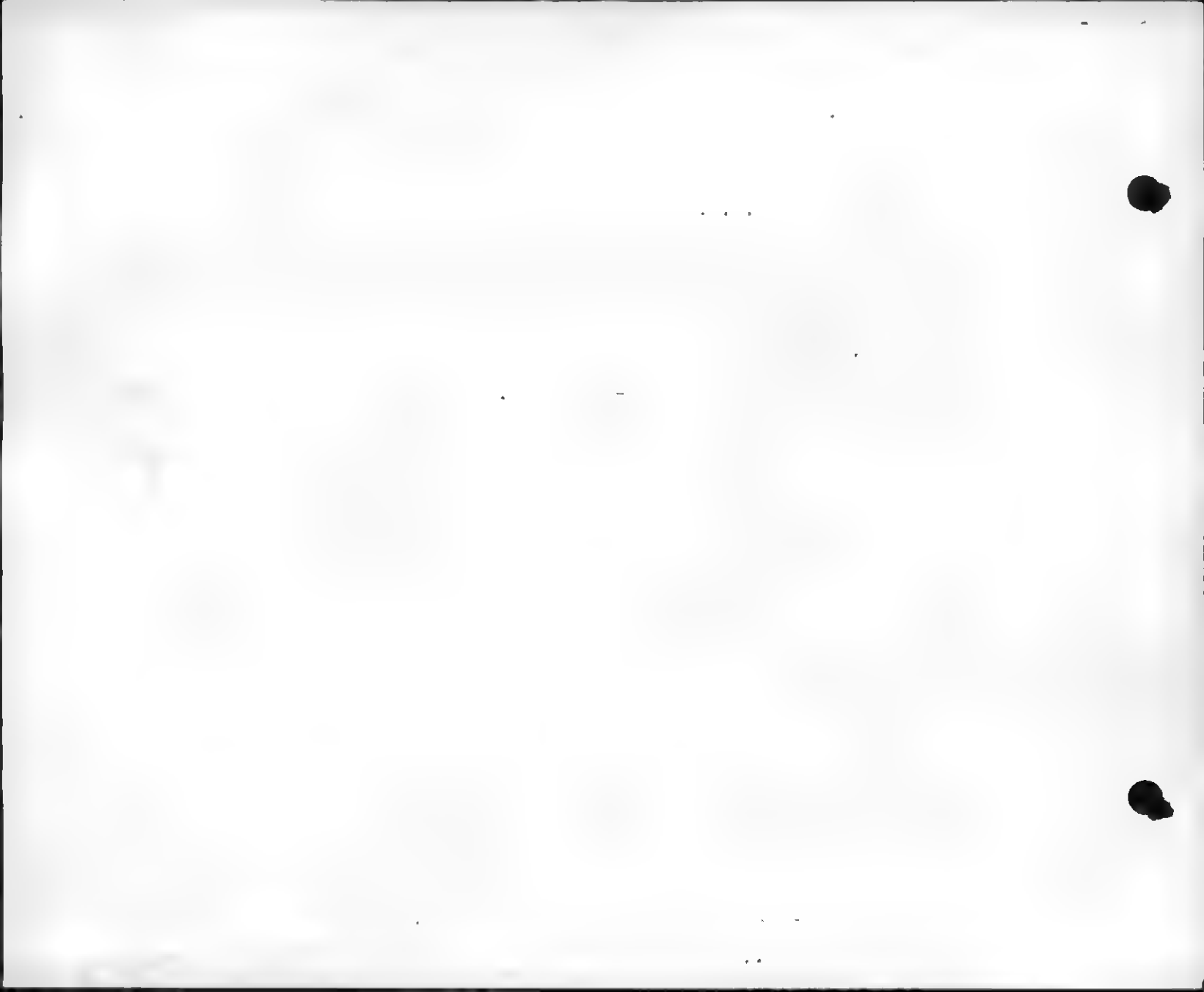


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4-66)
30M REV 1-66

16945										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16957																																																											
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																																											
DR. HAROLD										DECEMBER 23										30A.M.																																																											
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										7. UNDER 1 YEAR										8. UNDER 24 HRS.																													
MALE										WHITE										APRIL 20, 1897										71 YRS.										MONTHS										DAYS										HOURS										MIN.									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																																							
VIRGINIA										U.S.A.																				BALTIMORE																																																	
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
BALTIMORE										6815 TIMBERLANE ROAD										PHYSICIAN										CARDIOLOGIST																																																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. CITY OR TOWN										13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13d. STREET AND NUMBER																																																	
MARYLAND										BALTIMORE																				6815 TIMBERLANE ROAD																																																	
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																																					
DR. ELIAS										ADELE																				BIX																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																																																	
NO										220-46-5047										MRS. ELIZABETH BIX										6815 TIMBERLANE ROAD																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																																					
PART I. DEATH WAS CAUSED BY:																																																																															
IMMEDIATE CAUSE (a)										4129										2 yr																																																											
DUE TO, OR AS A CONSEQUENCE OF																																																																															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)																																																																					
DUE TO, OR AS A CONSEQUENCE OF										(c)																																																																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																																															
421																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																																																											
21d. INJURY OCCURRED While <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC										21f. LOCATION Street or R.F.D. No. City or Town County State																																																											
22a. I certify that (I) (this hospital) attended the deceased from Jan 1955 to Dec 23 1964 and that (I) (we) last saw the deceased alive on Dec 23 1964 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																																															
22b. SIGNATURE										DEGREE										ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c. DATE SIGNED																																																	
22d. PHYSICIAN'S NAME (Type)										JOSEPH GROSS										22e. ADDRESS										6911 PARK HEIGHTS AVENUE																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																																																	
BURIAL										12-25-68										CHIZUK AMANO (ARLINGTON)										BALTIMORE, MARYLAND																																																	
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																											
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD										DEC 30 1968										Charles Judge																																																											



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A 15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16946					16958						
1. DECEASED NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR			
DORIS NACE LENOIRA BLACK					DEC. Month 2 Day 1968 Year			1:20 M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		
FEMALE		CAU		5/12/1909			59 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		USA				Baltimore, Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson			Greater Balto. Hospital			Secretary			Banking		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Baltimore					City				4618 Marble Hall 21212		
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Roland Nace				Leonora Briggs							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT			Address			
No			216-44-2917		Edward A. Briggs (Uncle)			21214 6300 Burchwood Ave			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bone marrow depression 174x DUE TO, OR AS A CONSEQUENCE OF (b) Radiation therapy with gastro-intestinal DUE TO, OR AS A CONSEQUENCE OF (c) Hemorrhage and urinary tract hemorrhage											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
History of carcinoma of right breast											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 10/31, 1968, to 12/2, 1968, that (I) (we) last saw the deceased alive on 12/2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE ER Sowden					22c. DATE SIGNED 12/2/68						
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			12/5/1968		Loudon Park Cemetery			Baltimore, Md.			
24. FUNERAL DIRECTOR Eupenia K. Seitz 5209 York Road Balto. Md. 21212											
25a. REC'D BY REGISTRAR DEC 4 1968 25b. REGISTRAR'S SIGNATURE											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>16947</div> <div> <div>1</div> <div> <div>16959</div> <div>8</div> </div> </div>										
1. DECEASED-NAME					2a. DATE OF DEATH		2b. HOUR			
First Middle Last Marian Louise Bogia					Month Day Year December 21 68		8.10A			
3 SEX		4 RACE		5 DATE OF BIRTH		6. AGE (in years last birthday)		7. UNDER 1 YEAR		
Female		White		2-1-09		59 YRS		MONTHS DAYS HOURS MIN 59		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Maryland		U.S.A.				Baltimore				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
Towson			St. Joseph Hospital			Secretary			Banking	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Baltimore		Towson		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		508 Brook Rd, 21204	
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME						
First Middle Last				First Middle Last						
Robert Scarborough				Rachael Griffith						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)				16b SOCIAL SECURITY NO		17 INFORMANT		Address		
No				220-32-2870		Roland A. Bogia		(Same)		
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).)										
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral Broncho Pneumonia										
485 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
MEDICAL CERTIFICATION										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
		P.M. 19								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC.			21f LOCATION Street or RFD No City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from 12-17-1968, to 12-21-1968, that (X) (we) last saw the deceased alive on 12-21-1968, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.										
22b SIGNATURE					DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c DATE SIGNED		
Samuel C. Lee M.D.								12-21-68		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
Samuel C. Lee M.D.					7620 York Rd., Towson, Md. 21204					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		12/24/68		Lorraine Park		Woodlawn Balto.Co., Md.				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.					DATE DEC 24 1968		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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16948

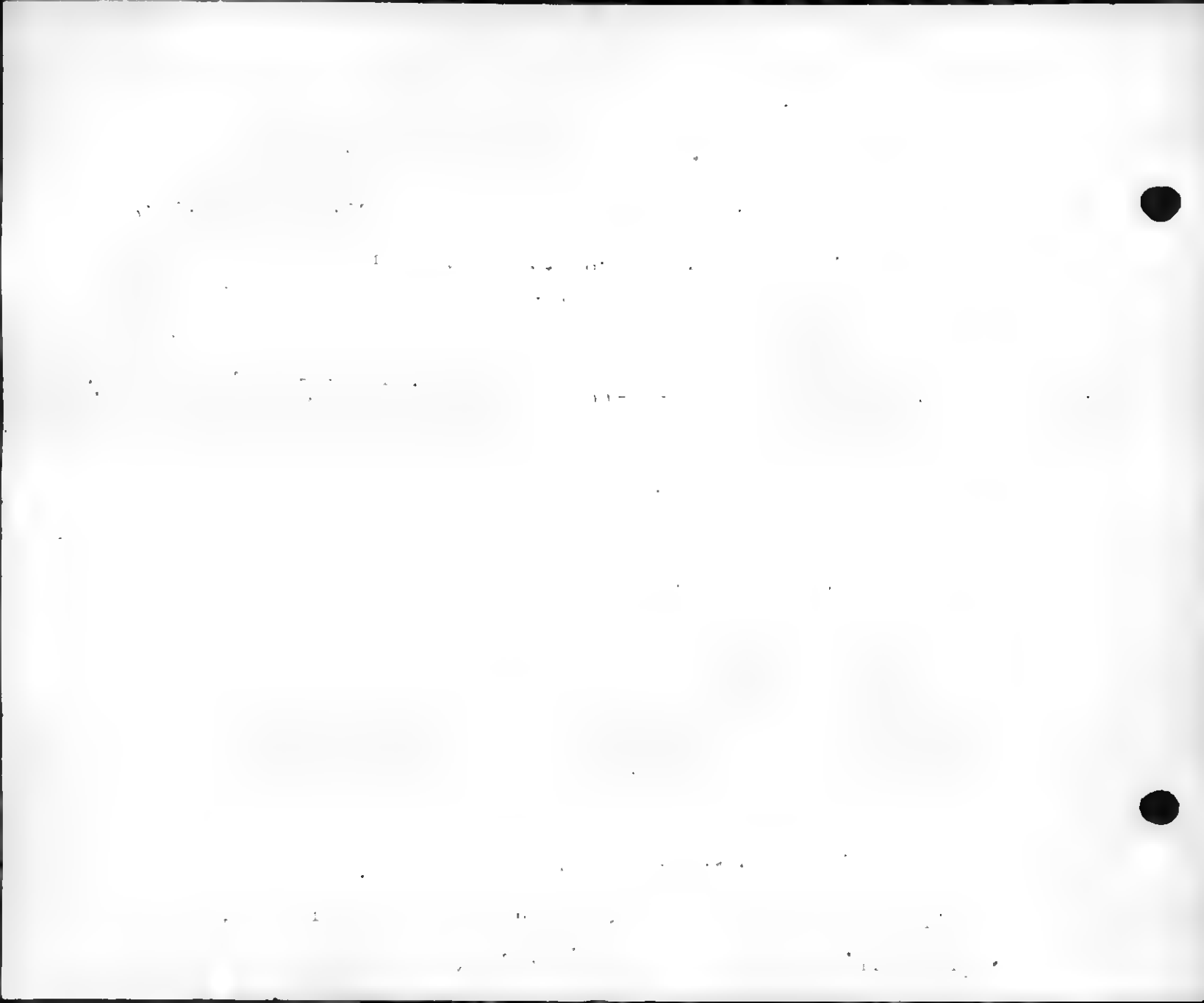
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16960

1. DECEASED-NAME (Type or print) T. THOMAS		First Middle Last		2a. DATE OF DEATH Month 12 Day 26 Year 1968		2b. HOUR 1025 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 9/11/1899		6. AGE (In years last birthday) 69 YRS.	
7a. BIRTHPLACE (State or foreign country) England		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County, Md.	
10. CITY OR TOWN OF DEATH Mount Wilson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson St. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Printer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Thomas Middle Bracken Last Bracken		15. MOTHER'S MAIDEN NAME First Claire Middle Townsend Last Townsend					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 143-05-7726		17. INFORMANT Richard T. Bracken-104 Hillton Ave 21228 Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia, bilateral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 3 mos. 3 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pulmonary Emphysema							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12/23/1968 , to 12/26/1968 , that (I) (we) last saw the deceased alive on 12/26/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William Newcomer				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/26/68	
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.				22e. ADDRESS Mount Wilson, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-28-68		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR W. Ellsworth Armacost-4600 Liberty Hgts. Ave				25a. REC'D BY REGISTRAR DEC 31 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (11)
304A REV. 1-68

16949

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16961

1 DECEASED-NAME (Type or print) First Middle Last Edgar Phillip Brandt			2a DATE OF DEATH Month Day Year 12 10 68		2b. HOUR P 6:50 M
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH 9/10/1906		6 AGE (In years last birthday) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (State or foreign country) BALTO.	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md		
10 CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Retired	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY Balto	13c CITY OR TOWN Towson	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 1840 EDGEWOOD RO
14 FATHER'S NAME First Middle Last CHARLES F 216-44-6711			15 MOTHER'S MAIDEN NAME First Middle Last SOPHIA L. HANSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 216-44-6711		17 INFORMANT Address WIFE SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myelogenous leukemia 1050 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 11/9 , 19 68 , to 12/10 , 19 68 , that (I) (we) last saw the deceased alive on 12/10 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Rudiger Breiteneker, M.D.				22c DATE SIGNED 12/11/68	
22d. PHYSICIAN'S NAME (Type) Rudiger Breiteneker, M.D.				22e. ADDRESS 6701 North Charles Street	
23a. BURIAL, CREMATION, REINTERMENT (Specify)		23b. DATE 12/16/68		23c. NAME OF CEMETERY OR CREMATORY Morland	
23d. LOCATION (City or Town) Balto		(County)		(State)	
24 FUNERAL DIRECTOR W. Deenman		ADDRESS 6062 Hay Rd		25a. REC'D BY REGISTRAR DATE DEC 16 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge					

MEDICAL CERTIFICATION



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 6 Film 3408 12/21/68

MARYLAND STATE DEPARTMENT OF HEALTH

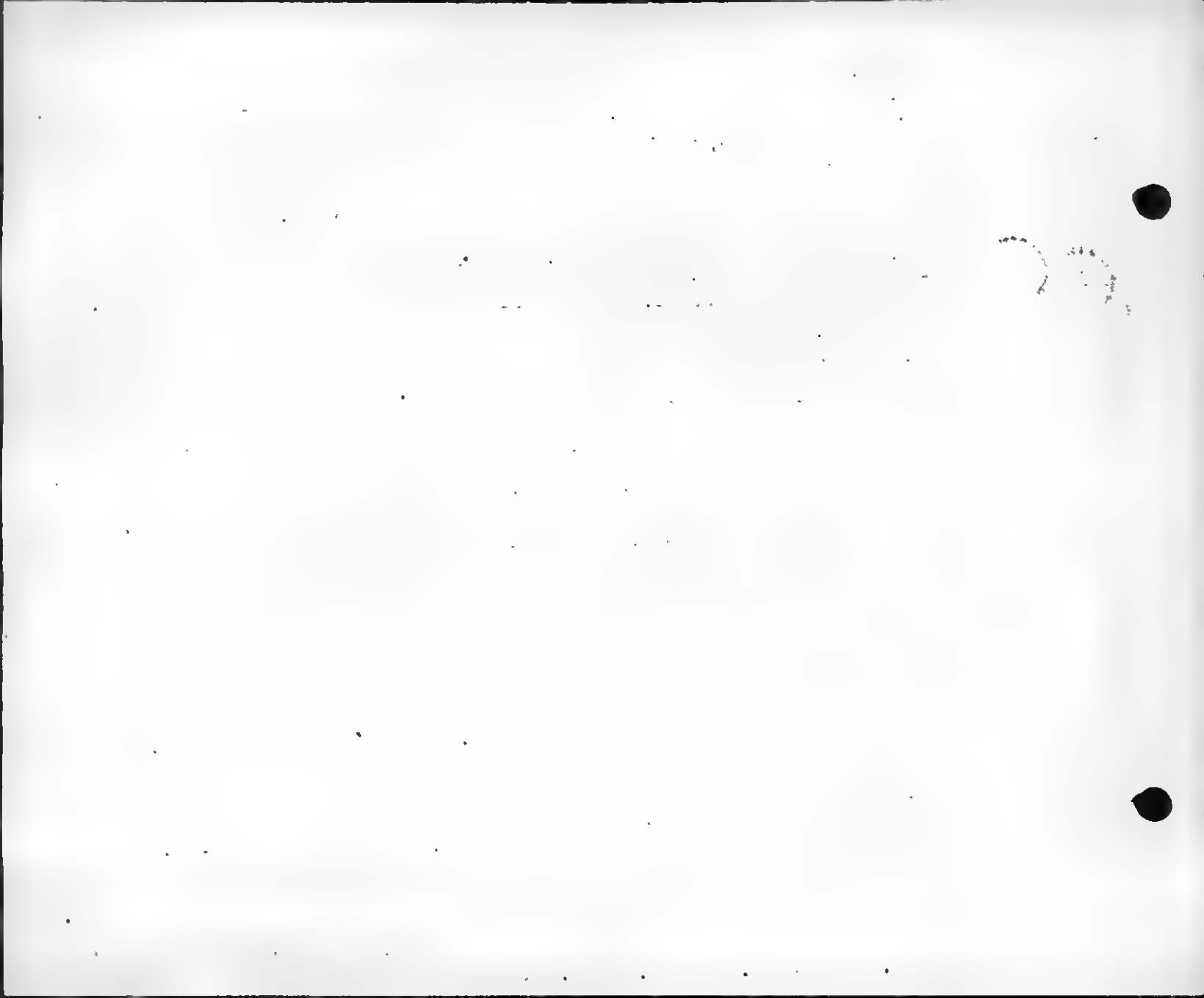
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16962

16950

CERTIFICATE OF DEATH

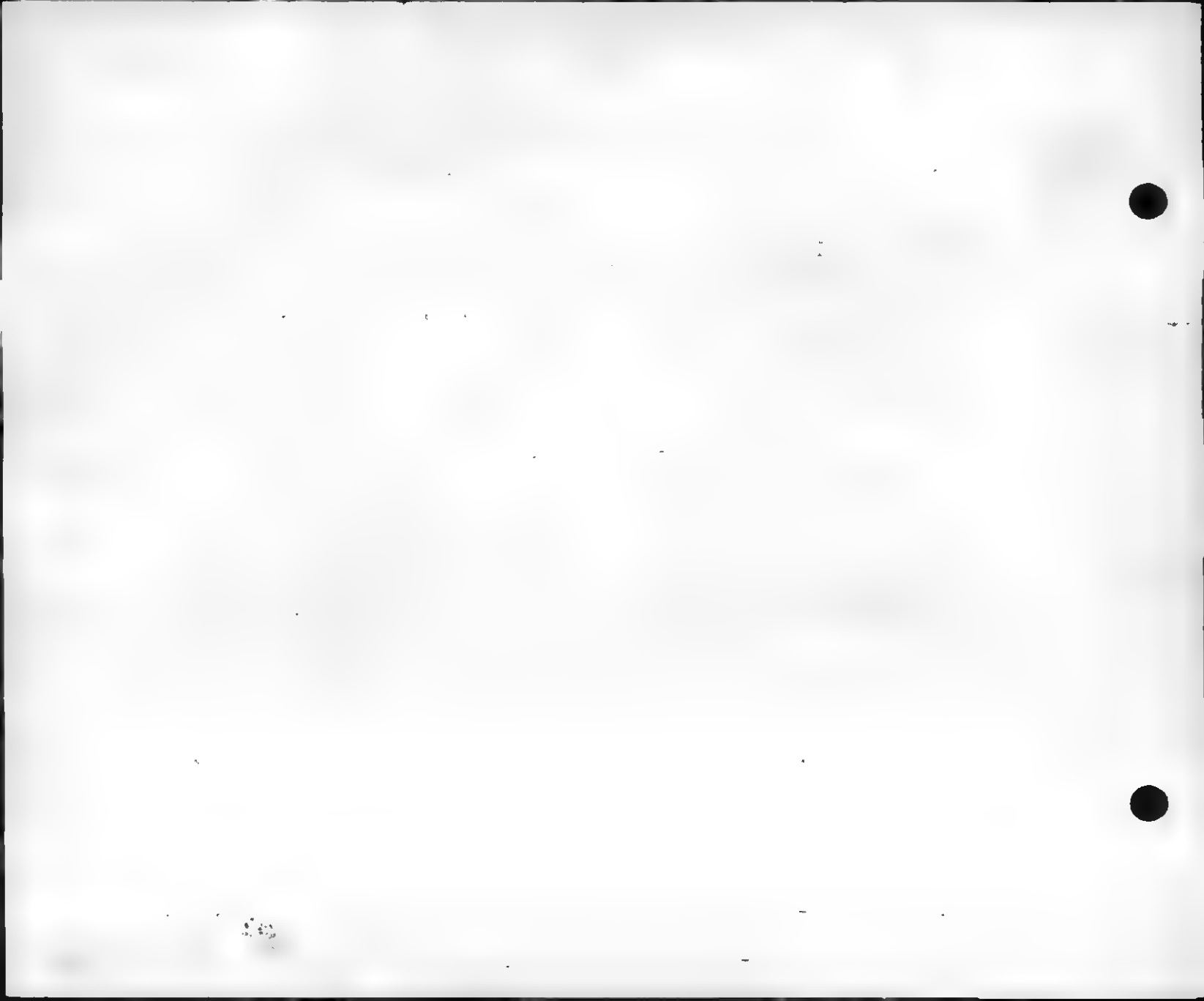
1. DECEASED NAME (Type or print) <i>Rosalin O. Brandt</i>			First Middle Last			2a. DATE OF DEATH Month Day Year <i>12 15 68</i>			2b. HOUR <i>6:15 AM</i>		
3 SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>11/5/1886</i>			6. AGE (In years last birthday) <i>82 YRS</i>		
7a. BIRTHPLACE (State or foreign country) <i>Altoona Pa.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Baltimore</i> Md		
10. CITY OR TOWN OF DEATH <i>Baltimore</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Grey Hall Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) <i>Maryland</i>			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME <i>Dustin Baum</i>			First Middle Last			15. MOTHER'S MAIDEN NAME <i>Anna Hamman</i>			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>			16b. SOCIAL SECURITY NO. <i>unknown</i>			17. INFORMANT <i>Thomas A. Brandt</i>			Address <i>1806 Old Joppa Road</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Chronic Myocardial failure</i>											<i>1 wk</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia</i>											<i>1 wk</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis Cordis Vasculard</i>											<i>2 yrs</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4+											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 1</i> , 19 <i>68</i> , to <i>12/15</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12/15</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>J.M. Baumgardner</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>12/16/68</i>		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS <i>Balto 21237</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>12/18/68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Altoona Pa.</i>		
24. FUNERAL DIRECTOR <i>John A. Moran, Inc.</i>						ADDRESS <i>3000 E. Balto. St.</i>			25a. REC'D BY REGISTRAR DATE <i>DEC 20 1968</i>		
									25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16951 CERTIFICATE OF DEATH 16963

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Dulany Towson NHC Home 111 West Rd</u>		d. STREET ADDRESS <u>7111 Campfield Road 21207</u>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First Middle Last		4. DATE OF DEATH <u>BRAY</u> Month <u>12</u> Day <u>21</u> Year <u>1968</u>	
5. SEX <u>male</u>		6. AGE (In years last birthday) <u>63</u> yrs.	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 21, 1905</u>	
10a. USUAL OCCUPATION (give kind of work done during most of working life, even if retired) <u>Smith's Oil Co</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md</u>	
13. FATHER'S NAME <u>James Terry Bray</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		17. INFORMANT <u>Mildred Bray</u> Address <u>7111 Campfield Road 21207</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma</u> 185 X DUE TO (b) <u>Ca of Prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>1/4 metastatic CVD</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>171 X</u> <u>Chronic Secondary Arterio Sclerotic</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>63</u> to <u>12-21</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-20</u> 19 <u>68</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas G Abbott</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Thomas G Abbott</u>		22d. ADDRESS <u>4509 Liberty Heights Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-24-68</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Ellsworth Armacost</u>		25a. REC'D BY REGISTRAR <u>DEC 26 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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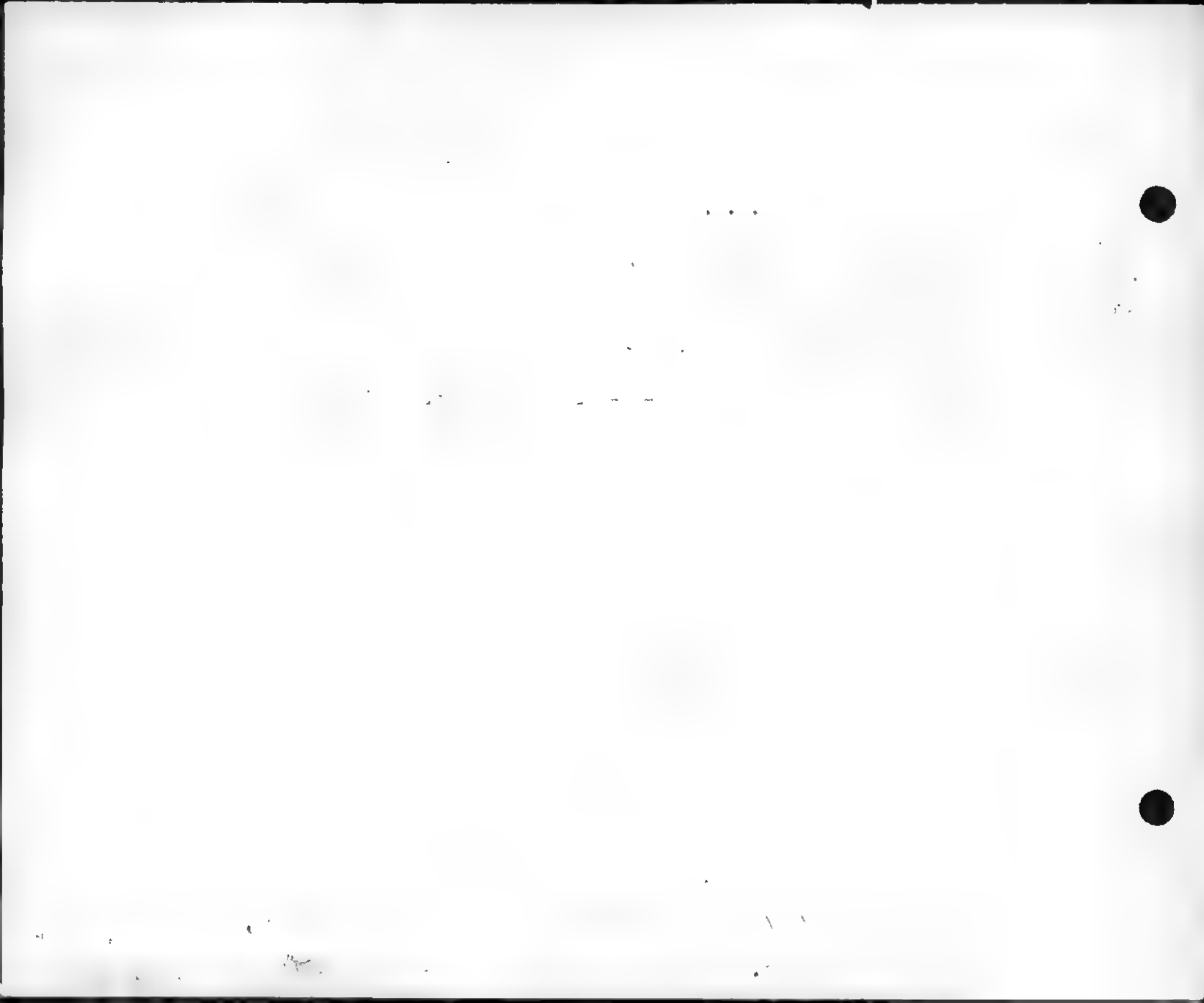
16952

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16964

1 DECEASED NAME (Type or print)		First William	Middle P.	Last Bristow	2a DATE OF DEATH Month Day Year December 20, 1968		2b HOUR 1:15 P.M.	
3 SEX Female	4 RACE White	5 DATE OF BIRTH 4-30-1887			6 AGE (In years last birthday) 81 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOUR MIN
7a BIRTHPLACE (State or foreign country) Baltimore	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore		Md		
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived last year) Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 5703 Carter Avenue #21214		
14 FATHER'S NAME First Middle Last Robert Applegarth		15 MOTHER'S M.A.DEN NAME First Middle Last Nannie Phillips						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b SOCIAL SECURITY NO. 024-03-7025D		17 INFORMANT Address Mr Thomas B Gier Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Probable pulmonary embolism with history of 4199 myocardial infarction. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State				
22a I certify that (I) (this hospital) attended the deceased from November 27, 1968, to December 20, 1968, that (I) (we) last saw the deceased alive on December 20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Lilia C. Baldonado				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED December 20, 1968		
22d. PHYSICIAN'S NAME (Type) Lilia Baldonado, M.D.				22e. ADDRESS 7620 York Road, Towson, Md. 21204				
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 12/24/68		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24 FUNERAL DIRECTOR ADDRESS Leonard J Ruck Inc. Baltimore, Maryland				25a. REC'D BY REGISTRAR DEC 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



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VR A15
30A REV. 4-68

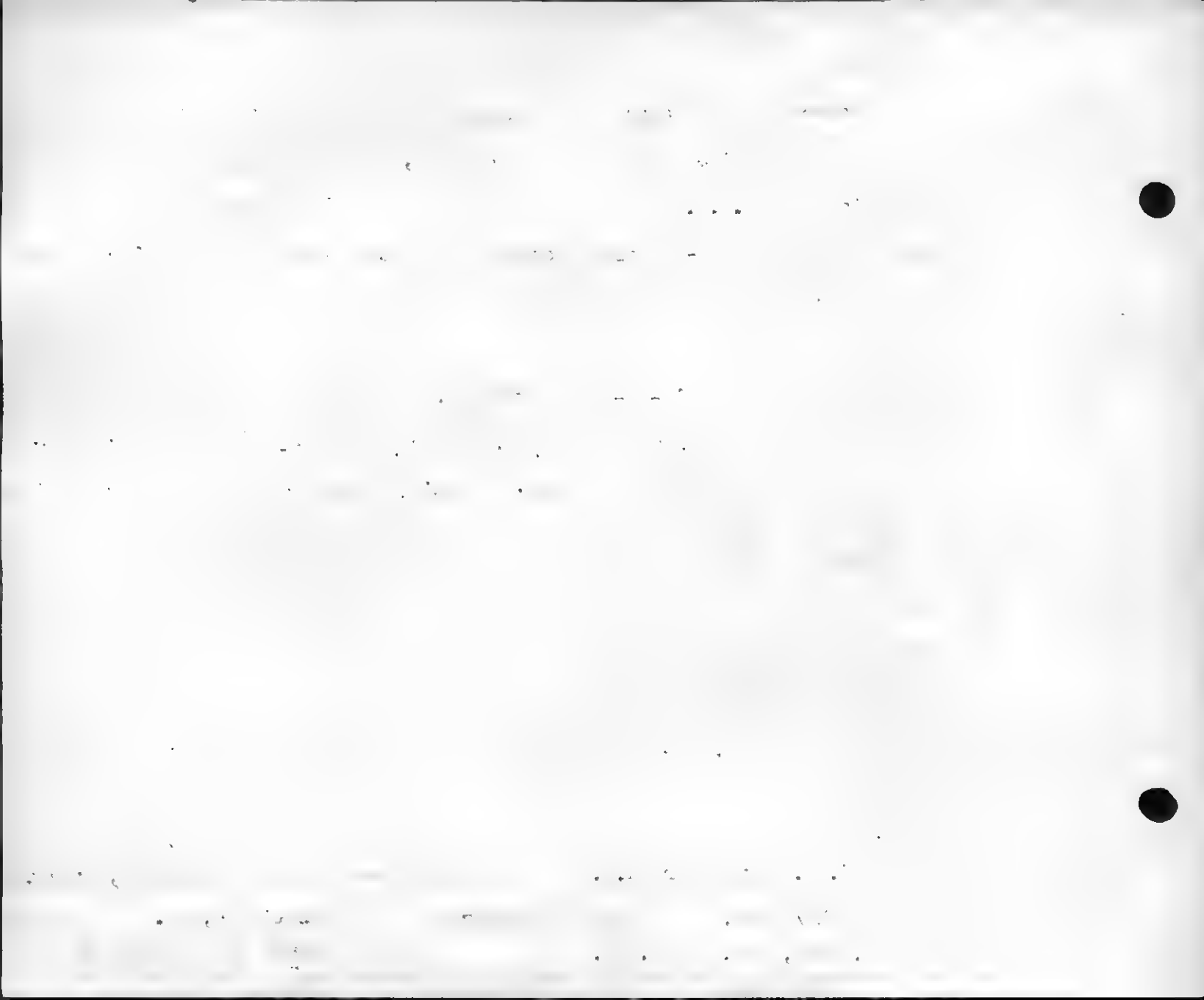
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16953

CERTIFICATE OF DEATH

16965

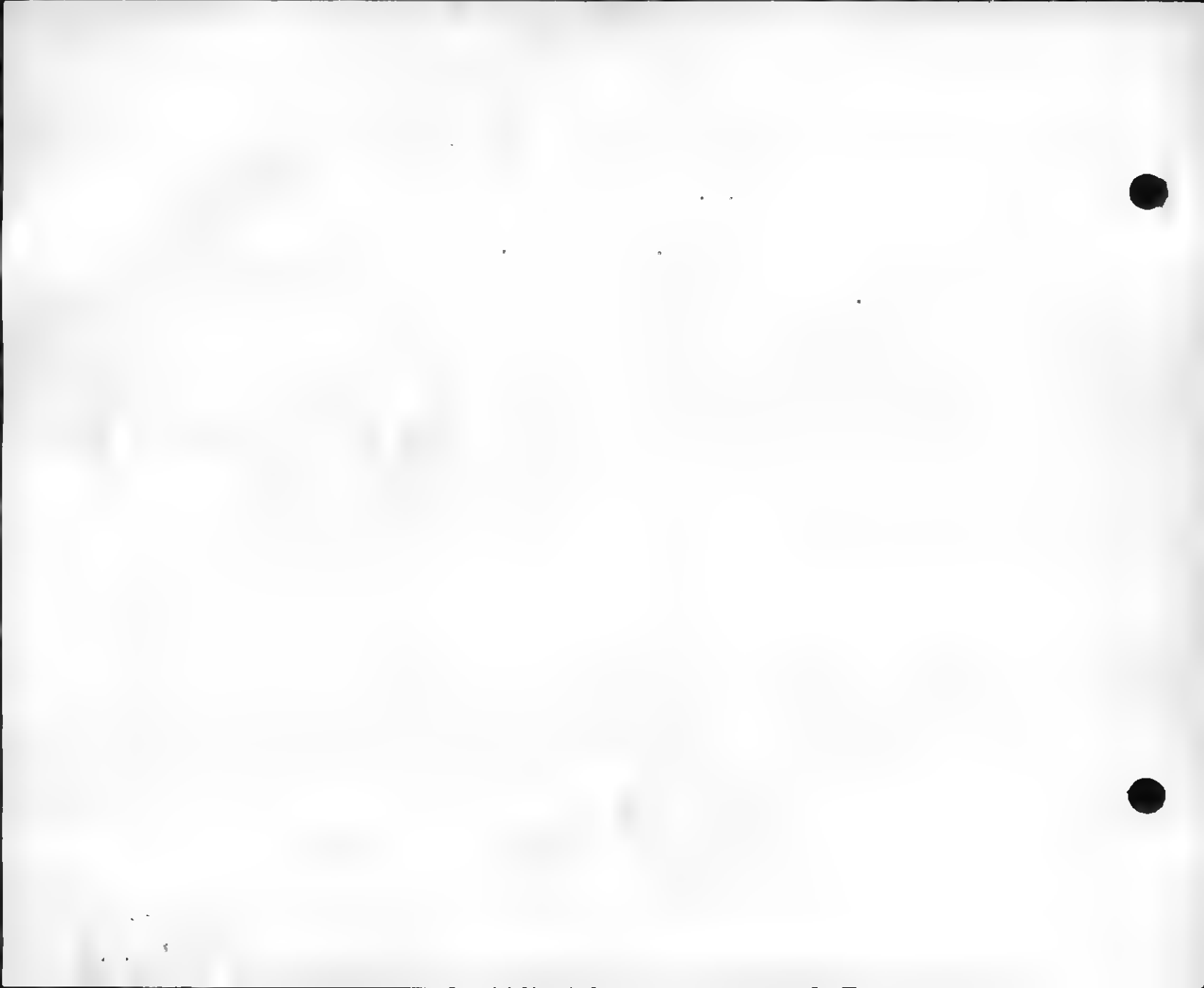
1. DECEASED-NAME (Type or print) Raymond Hayse Bristow			2a. DATE OF DEATH Month 12 Day 12 Year 68			2b. HOUR M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 10, 1905		6. AGE (In years last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN		
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA-St Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY Delicatessen				
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6933 Harford Rd	
14. FATHER'S NAME First Middle Last Raymond J Bristow			15. MOTHER'S MAIDEN NAME First Middle Last Blanche Lewis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 216-01-9706		17. INFORMANT Mrs Alma A Bristow		Address Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Cardiac Vascular Disease DUE TO, OR AS A CONSEQUENCE OF 7109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Sudden 5 yrs								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4-11										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 5/24 , 19 63 , to 12/12 , 19 68 , that (I) (we) last saw the deceased alive on 12/5 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE G. M. Baumgardner		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/12/68				
22d. PHYSICIAN'S NAME (Type) G. M. Baumgardner M.D.		22e. ADDRESS 8552 Philadelphia Rd Baltimore, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/16/68.		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.				
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				ADDRESS 21214		25a. REC'D BY REGISTRAR DEC 13 1968		25b. REGISTRAR'S SIGNATURE [Signature]		



16954		Item 13e Film G408 1/10/c9 ts		16966	
1 DECEASED-NAME (Type or print) Lottie Carroll Brooks			2a DATE OF DEATH 12 Month 27 day 68		2b. HOUR 6:45 P.M.
3 SEX Female	4. RACE White	5. DATE OF BIRTH 9-30-1883		6. AGE (In years last birthday) 85 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore County		
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. County Gen. Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Balto	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Chapey / 4411 N. Home
14. FATHER'S NAME First Middle Last Thomas Mason		15. MOTHER'S MAIDEN NAME First Middle Last Laura Hudgins			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO (If yes give year or dates of service)		17. INFORMANT Dorothy H. Conson 6700 Lachlan Cr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 12-23, 1968 , to 12-27, 1968 , that (I) (we) last saw the deceased alive on 12-27, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Angela Topano		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-27-68	
22d. PHYSICIAN'S NAME (Type) ANGELITA TOPANO		22e. ADDRESS BO 814			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/31/68	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City or Town) (County) (State) Balt. Co. Maryland
24. FUNERAL DIRECTOR Wm. Carl-Brooks West Inc		6212 Balt. Nat. Pk. Balt. Md		25a. REC'D BY REGISTRAR JAN 3 1969	25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

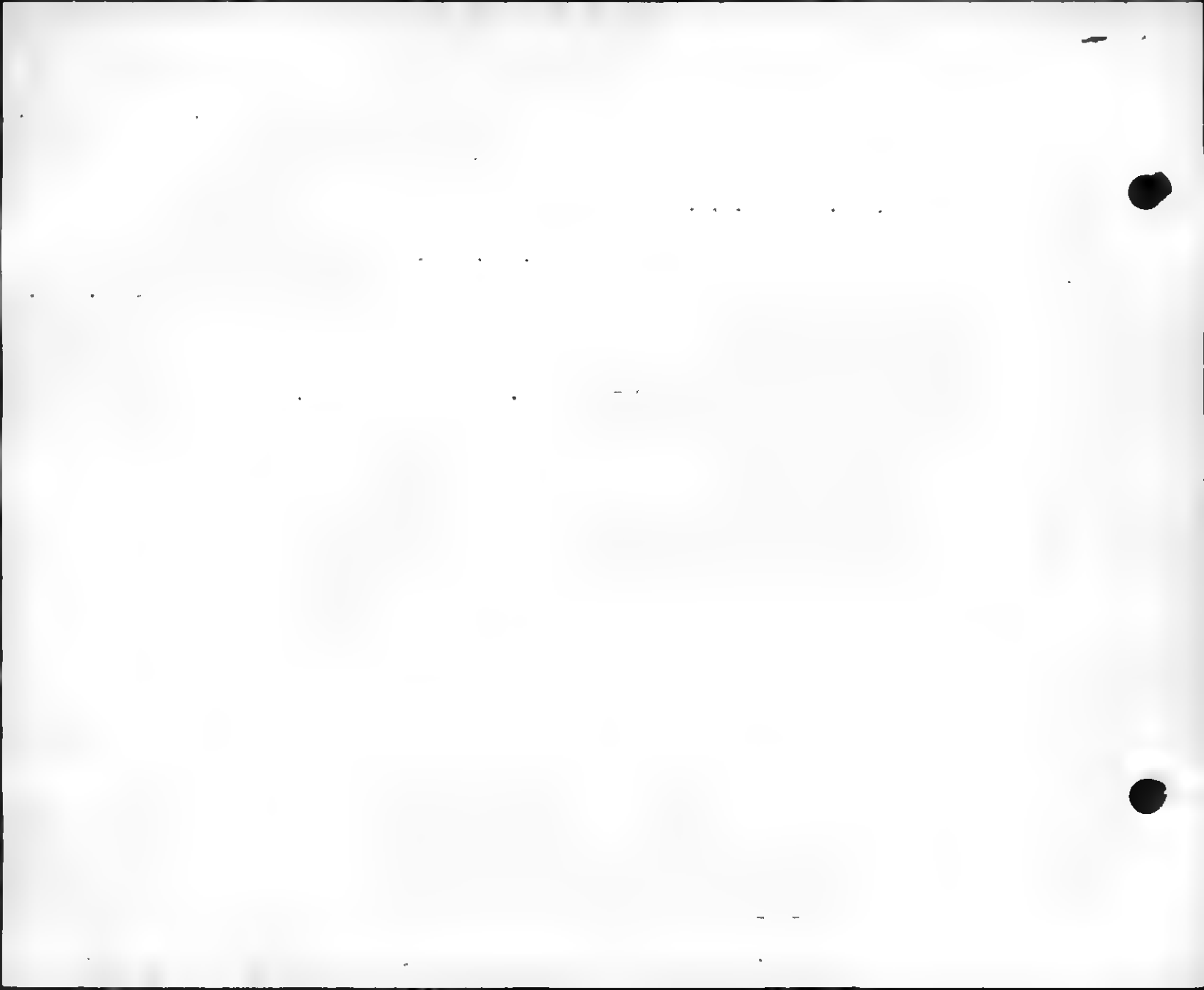


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
IDA			BROTHERS			DECEMBER 25, 1968		1:30 P.M.		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
FEMALE		WHITE		12-25-1902		66 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
BALTIMORE, MD.		U.S.A.				BALTIMORE Md.				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE			6984 MILBROOK PK. DR., APT. 1 C			HOUSEWIFE		AT HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			BALTIMORE				YES		6984 MILBROOK PK. DR., APT. 1C	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last						
JACOB WEINSTEIN				SARAH FISHBEIN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
NO			212-36-3252		MR. SEYMOUR BROTHERS, 5505 RUSK AVENUE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cerebral Hypertensive Infection</i> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes mellitus</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, etc. Off CE building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>1965</i> , to <i>Dec</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Leonard Golombek</i>				DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)		LEONARD GOLOMBEK			22e. ADDRESS 7039 LIBERTY ROAD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		12-27-68		SHAAREI TFILOH		BALTIMORE, Maryland				
24. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				25a. REC'D BY REGISTRAR DEC 30 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



16956

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16968

1. PLACE OF DEATH a. COUNTY <i>Balti.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Balti.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bradshaw</i>		c. LENGTH OF STAY IN 1b <i>50 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bradshaw</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>12 Peppers Rd.</i>				d. STREET ADDRESS <i>Peppers Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>MARGARET W. BROWN</i>				4. DATE OF DEATH Month Day Year <i>12 / 1 / 68 19</i>			
5. SEX <i>F.</i>		6. COLOR OR RACE <i>NEGRO</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12/18/1892</i>	
9. AGE (in years last birthday) <i>75</i> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Private Home</i>		11. BIRTHPLACE (State or foreign country) <i>md.</i>	
10c. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Joshua Kinder</i>		14. MOTHER'S MAIDEN NAME <i>Sophia Taylor</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>Unknown</i>		17. INFORMANT Address <i>Margaret Johnson, Perry Hall, Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> 4100 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>Arterial sclerosis heart disease with</i> DUE TO <i>hypertension</i> (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>4201</i>							INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> 1950 to <i>Dec 1</i> 1968, that (I) (we) last saw the deceased alive on <i>Dec 1</i> 1968, and that death occurred at <i>3 P.M.</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Fred O. Hodous</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12-1-68</i>	
22c. PHYSICIAN'S NAME (Type) <i>Fred O. Hodous</i>				22d. ADDRESS <i>Edgewood Md.</i>			
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/5/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Asbury M. Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>White Marsh, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. L. Chetman</i>				25a. REC'D BY REGISTRAR <i>J-1701 M. Cullough</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
				DATE <i>DEC 9 1968</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

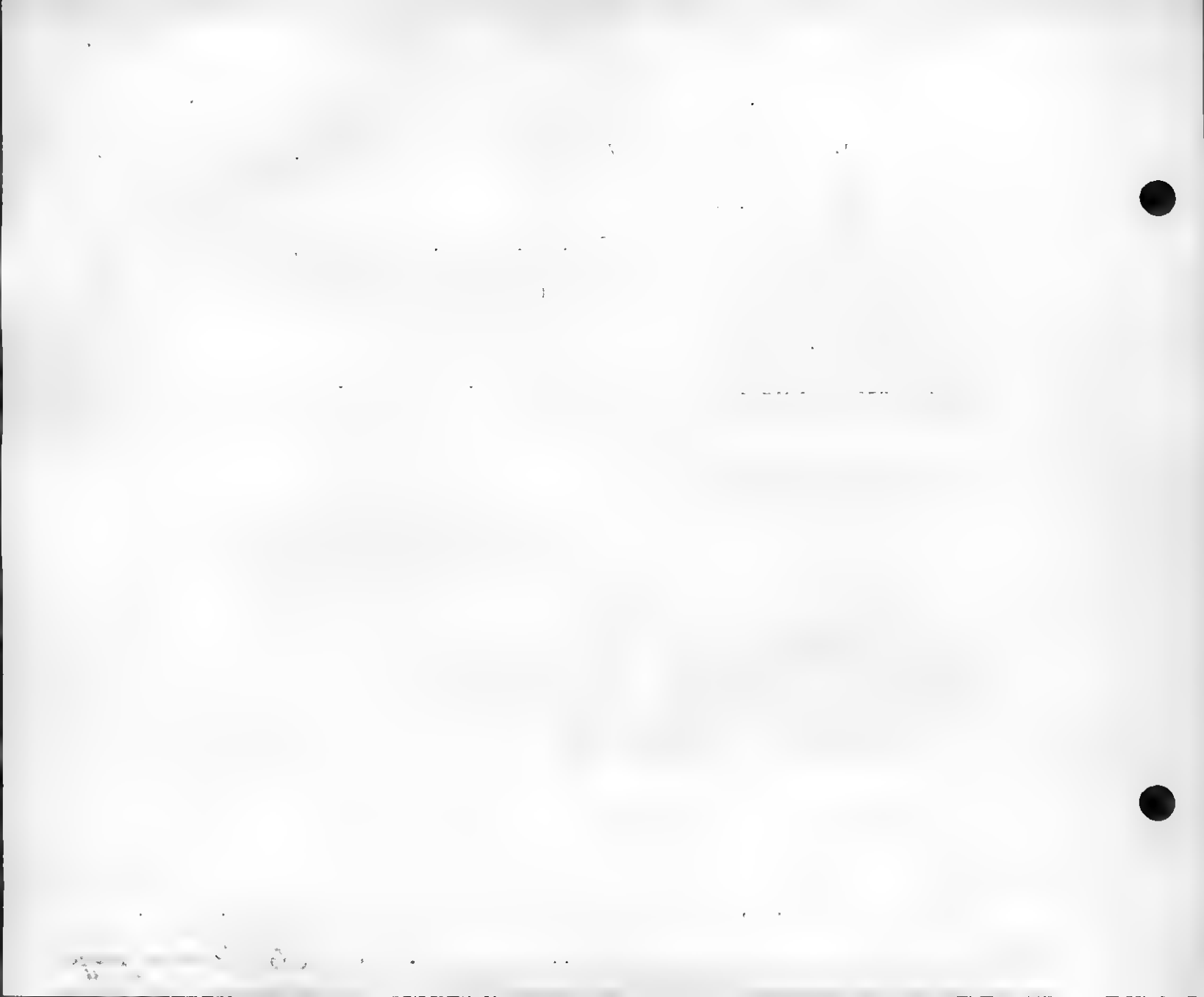
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

16957

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

16969

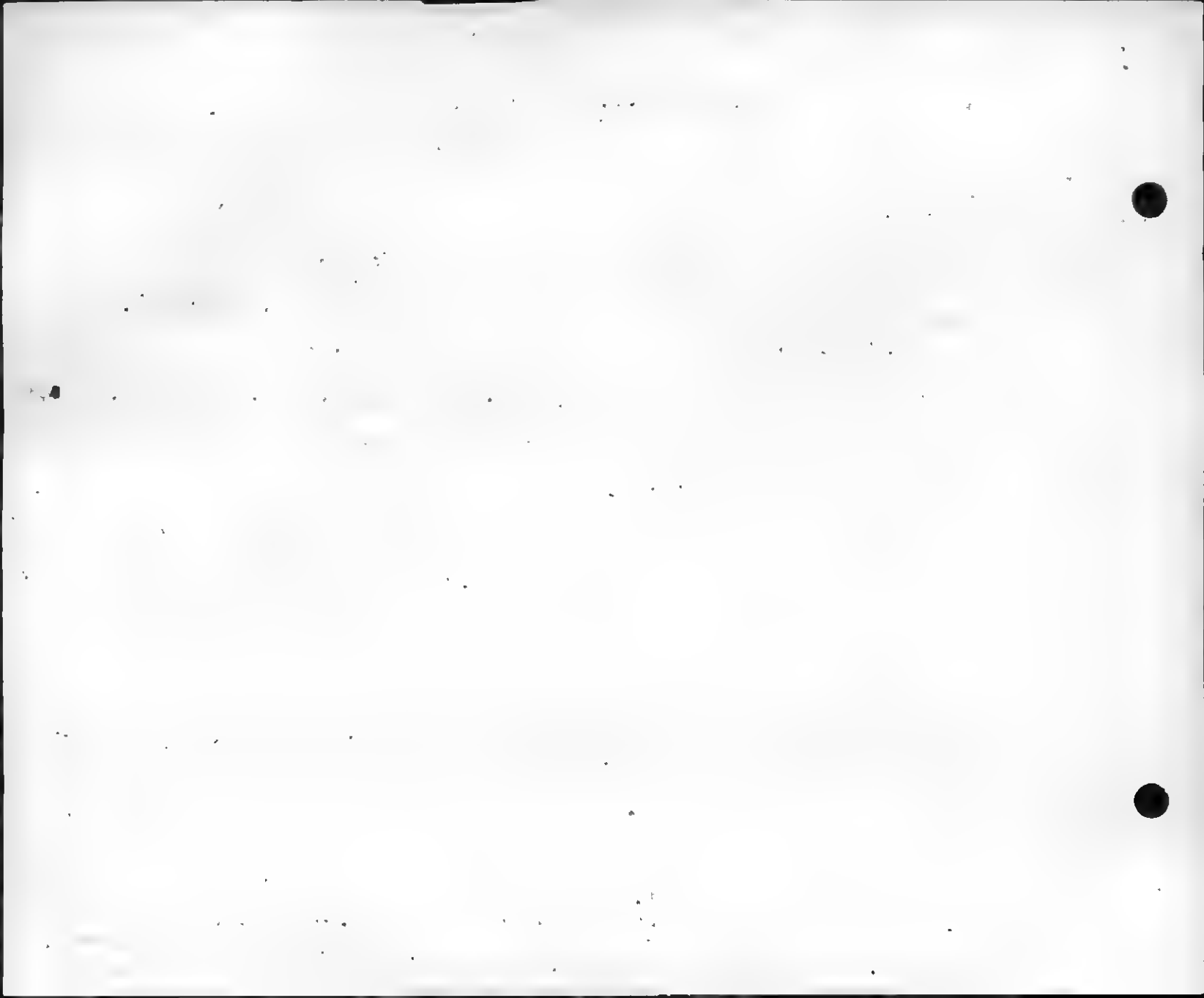
1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF ESTI DEATH MATED				2b HOUR	
GENE B. BRUNS								December 31 1968 10 PM					
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR	
Female	Cau.	12-15-1911		57 YRS.		MONTHS		DAYS		December 31 1968 10 PM			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH							
Pennsylvania		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore		Md					
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY	
Baltimore 21212				207 N. Tyrone Rd.				Homemaker				Home	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Maryland				Baltimore		Baltimore 21212		NO <input type="checkbox"/>		207 N. Tyrone Road			
14 FATHER'S NAME						15 MOTHER'S MAIDEN NAME							
Robert S. Brown						Mary							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO		17 INFORMANT				ADDRESS			
NO						John J. Bruns, Jr.,				Same as # 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>												Sudden	
4109 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c) DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
4													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
CAUSE OF DEATH				19 P.M.									
21d INJURY OCCURRED		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town		County		State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from? Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED			
EXAMINER'S NAME (Type)				Charles F. O'Donnell				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		1/31/68			
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
								ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)			
Burial		Jan. 4, 1969		Greenhill Cemetery		Waynesboro. Penna.							
24 FUNERAL DIRECTOR						ADDRESS		25a REC'D BY REG STRAR		25b REGISTRAR'S SIGNATURE			
Wm. Cook-Brooks						Towson, 1050 York Rd., Towson, Md		JAN 3 1969		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16958		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		16970	
Item#8 Film#G408 1c/31/68 vmp					
1. DECEASED-NAME (Type or print) First Middle Last NAN BRUNZELL			2a. DATE OF DEATH Month Day Year 12 20 68		2b. HOUR 11A. M
3 SEX F.	4 RACE W	5. DATE OF BIRTH 7/1/82		6 AGE (In years last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) United States	7b. CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH CATONSVILLE	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SHANGRI-LA HRS	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE 212d 212d	13b. COUNTY Catonville	13c. CITY OR TOWN Catonville	13d. INSIDE CITY, LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 58 N. Rogers Ave.	
14. FATHER'S NAME First Middle Last S. Thompson Corn		15. MOTHER'S MAIDEN NAME First Middle Last Emma B. Corn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service) no		16b. SOCIAL SECURITY NO.		17 INFORMANT Address Mrs. Carl Carlson, 58 N. Rogers Ave. 21203	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia Embolism</u> 4519 DUE TO, OR AS A CONSEQUENCE OF (b) <u>PHLEBO-THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>ASCVD - Fracture L. Hip old - Cataracts - Kyphosis Marked</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u> <u>days</u>
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>8-31-1968</u> , to <u>12-20-1968</u> , that (I) (we) last saw the deceased alive on <u>12-20-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Cesar Valle Cervero</u>		DEGREE	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO		22e. ADDRESS 8629 Liberty Rd		22c. DATE SIGNED 12-20-68	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/23/68	23c. NAME OF CEMETERY OR CREMATORY Sam Houston National		23d. LOCATION (City or Town) (County) (State) Rt. Sam, Texas	
24. FUNERAL DIRECTOR Howard County Funeral Home of Harry H. Witzke, Ellicott City, Md. 21043		25a. REC'D BY REGISTRAR DEC 23 1968		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



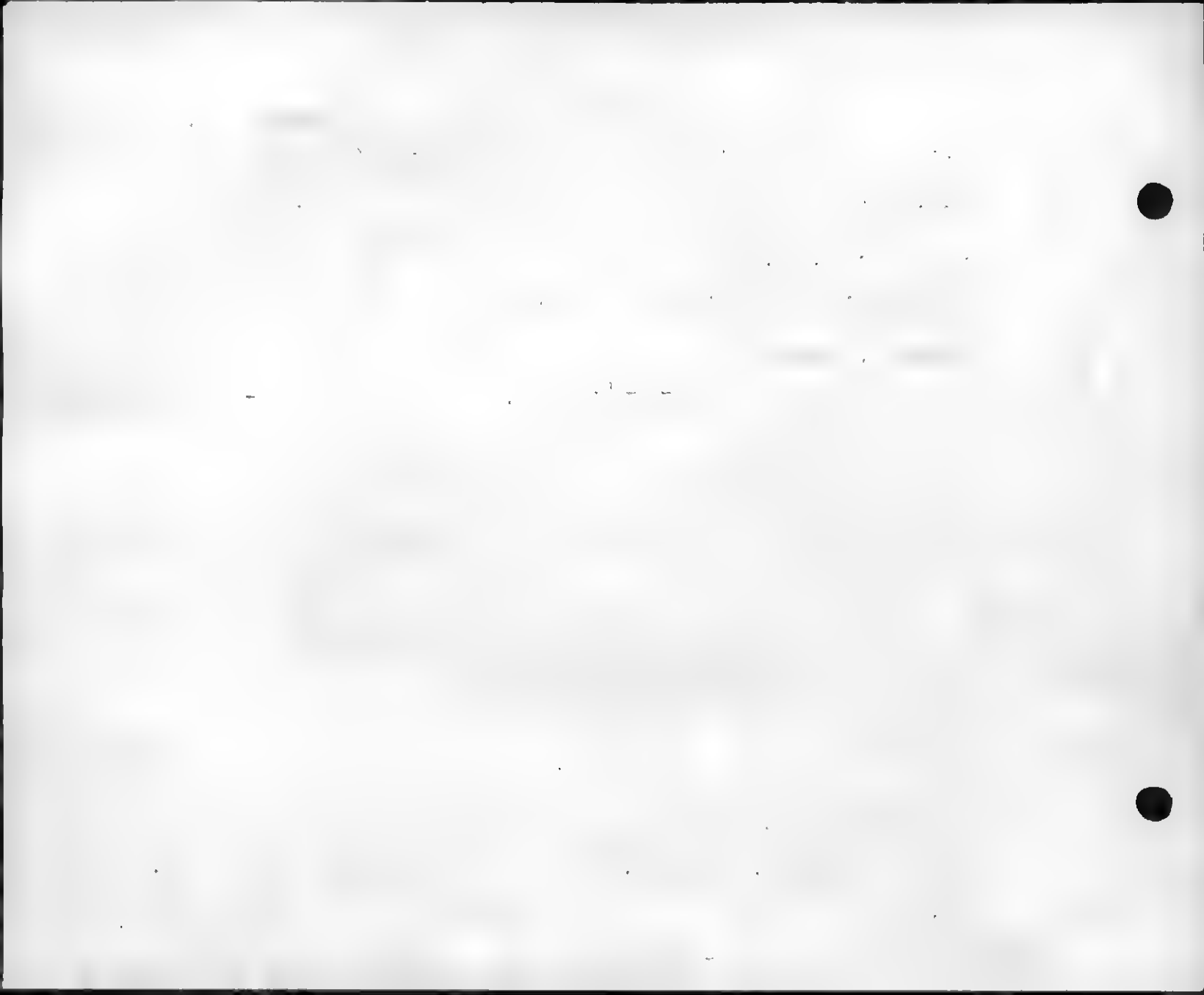
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be procured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is to be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First MARY Middle ELIZABETH Last BUCHANNON			2a. DATE OF DEATH		2b. HOUR	
						Month 12 Day 2 Year 1968		9A M	
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR	
FEMALE		COLORED		12-28-03		64 YRS.		MONTHS DAYS HOURS M.N.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
VIRGINIA		U.S.A.				BALTIMORE		Md.	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
GLENARM		Maryland Box 217-Glenarm,				Domestic		Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		BALTIMORE		GLENARM		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Box 217-Glenarm, Md.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Ernest Middle Walker Last Walker			First Daisy Middle Jackson Last Jackson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			214-18-5681		Charles Buchannon Box 217 Glenarm, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>									3 hr.
492 X DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Heart Failure</u>									3 hr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>Chronic Emphysema</u>									10 yr.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
527.1									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>67</u> , to <u>Dec.</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov-26</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>12/2/68</u>	
22d. PHYSICIAN'S NAME (Type) Dr. S. E. HARRIS						22e. ADDRESS 8100 Harford Road			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12-5-1968		Mt. Auburn Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR ADDRESS Marshall W. Jones, Jr. 1735 Harford Ave.						25a. REC'D BY REGISTRAR DATE DEC 4 1968		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the pages, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AND (4)
45M - 1/69

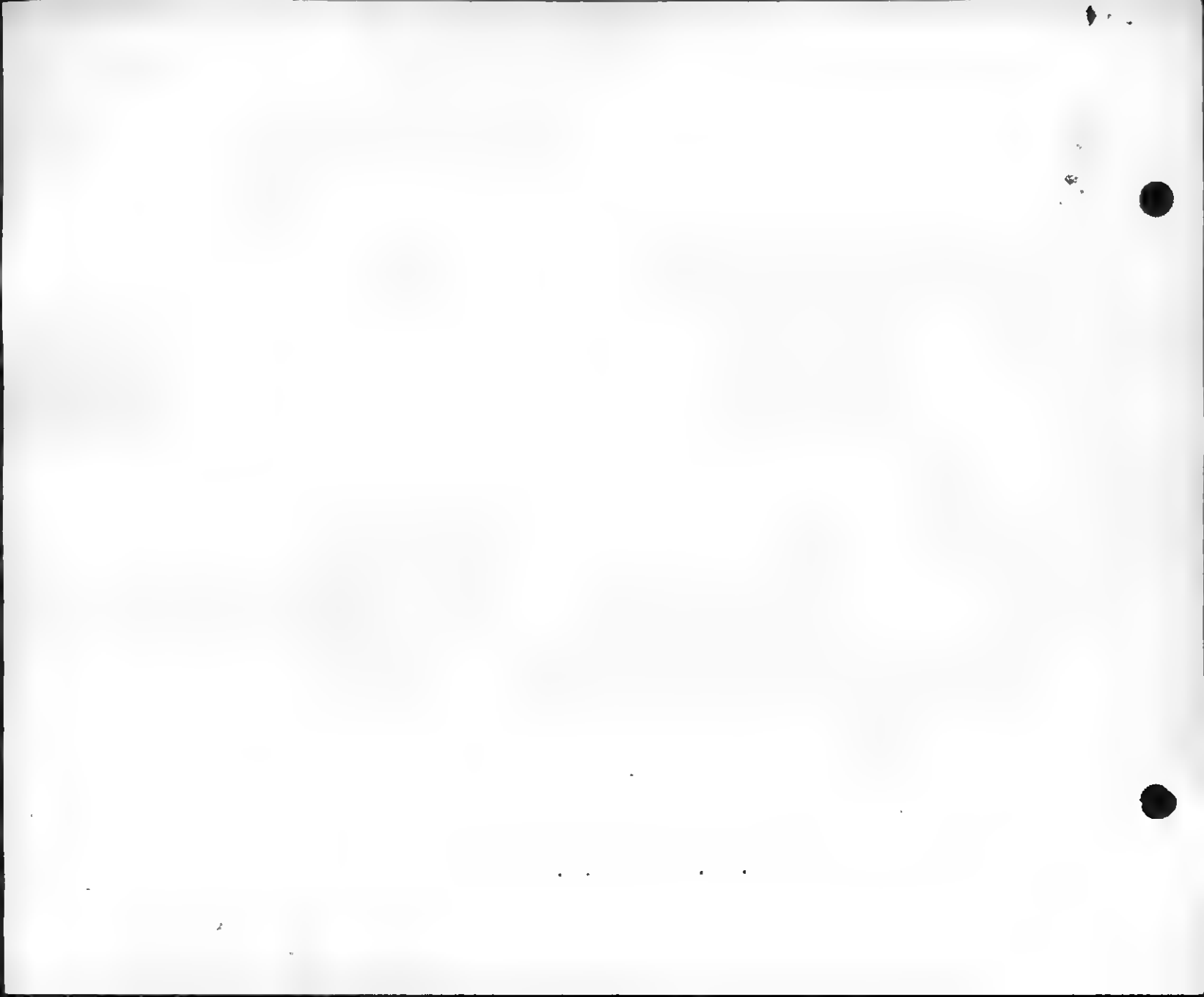
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16961

CERTIFICATE OF DEATH

18525

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR	
Dawn			Michelle	Burall	December 7, 1968		10:09	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
Female	White		December 4, 1968		YRS. 3			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH			
Maryland					Baltimore			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Towson			St. Joseph Hospital					
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER	
Maryland					Baltimore		6880 McClean Blvd.	
14 FATHER'S NAME			15 MOTHER'S MA DEN NAME					
First Middle Last Bryan Nicholas Burall			First Middle Last Patricia Garland Winterling					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b SOCIAL SECURITY NO.		17 INFORMANT Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> Immaturity <u>777X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
22a. INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		22b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		22c. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (A) (this hospital) attended the deceased from <u>12-4-</u> , 19 <u>68</u> to <u>12-7-</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>December 7,</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death.								
22b. SIGNATURE		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. DATE SIGNED		
<u>Samuel C. H. Lee, M.D.</u>		Samuel C. H. Lee, M.D.		7620 York Road, Towson, Md. 21204		12-9-68		
23a. BURIAL (CREMATION) REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
		1-24-68		O. of Md. Med. School		Baltimore Md.		
24 FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
				DATE JAN 29 1969		<u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
16992
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16973

1 DECEASED NAME (Type or print) Jeffrey Michael BURALL			2a. DATE OF DEATH Month 12 Day 5 Year 1968			2b. HOUR 8:20 A M	
3 SEX Male		4. RACE White		5 DATE OF BIRTH 12/4/68		6 AGE (In years last birthday) Newborn	
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore, Md	
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) N/A		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 6880 McClean Blvd.							
14 FATHER'S NAME First Middle Last Bryan Burall			15 MOTHER'S MAIDEN NAME First Middle Last Patricia Garland Winterling				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17 INFORMANT Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Immaturity DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (this hospital) attended the deceased from 12/4/ , 19 68 , to 12/5/ , 19 68 , that (X) (we) last saw the deceased alive on 12/5/ , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Lawrence F. Misanik</i>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/6/68	
22d. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.				22e. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12-6-68		23c. NAME OF CEMETERY OR CREMATORY U. of Md. School		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE DEC 16 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

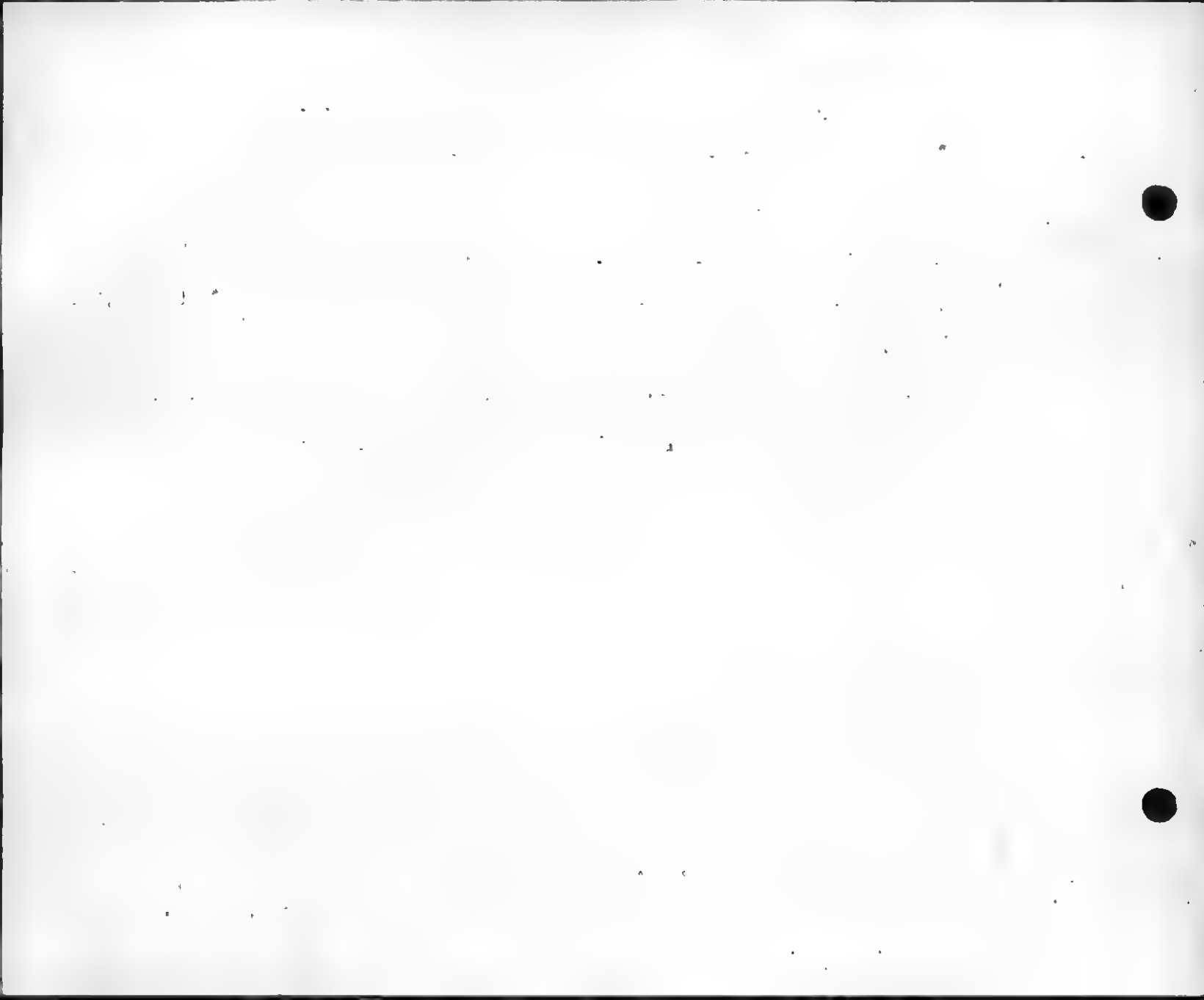


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

<div style="display: flex; justify-content: space-between;"> 16993 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16974 </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>											
1. DECEASED-NAME (Type or print) RICHARD P BURK						2a. DATE OF DEATH DEC. Month 19 Day 68 Year			2b. HOUR 2:00 M		
3. SEX MALE		4. RACE Caucasian		5. DATE OF BIRTH 7-15-1897			6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS M.N.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE			Md.		
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GR. BALTO. MED. CENTER			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Blenheim Rd. Phoenix, Md.		
14. FATHER'S NAME First Middle Last Andrew Burk				15. MOTHER'S MAIDEN NAME First Middle Last Katherine Trapp							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 218-34-1620 A		17. INFORMANT Address Mrs. Lucille Burk Blenheim Rd. Phoenix, Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4129											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 12-14 , 19 68 , to 12-19 , 19 68 , that (I) (we) last saw the deceased alive on 12-19 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE D.G. Carolis MD				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-19-68					
22d. PHYSICIAN'S NAME (Type) D.G. CARALIS, MD.				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12-21-1968		23c. NAME OF CEMETERY OR CREMATORY St. John's Blenheim			23d. LOCATION (City or Town) (County) (State) Phoenix, Maryland				
24. FUNERAL DIRECTOR Wm. Cook Brooks Tewson				ADDRESS 1650 York Rd. Towson, Md.		25a. REC'D BY REGISTRAR DEC 23 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

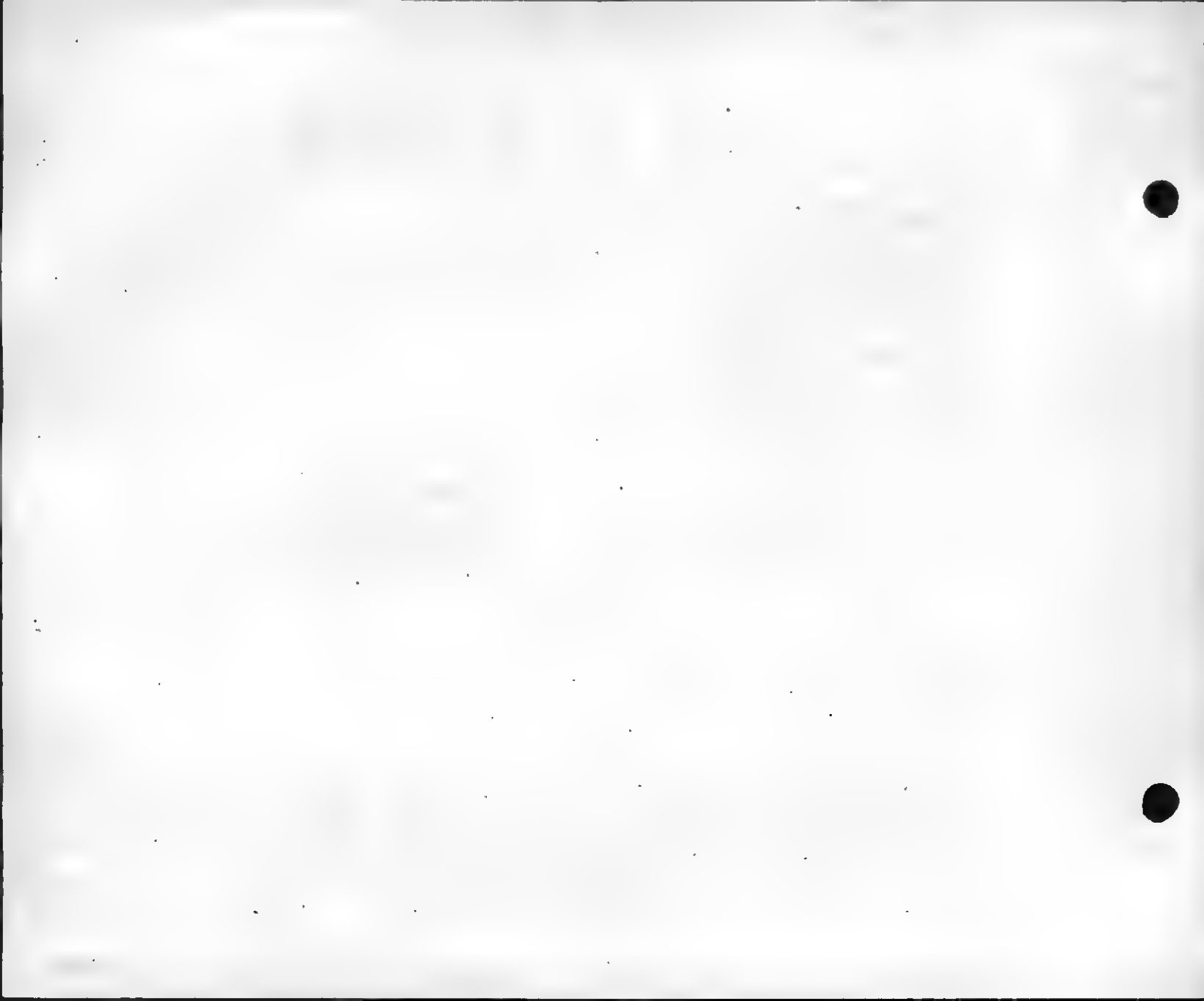


**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH MATED			2b. HOUR		
Susanna O.			Burlage			December 1968			A M		
3 SEX	4. RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	White	4-27-1935	83 YRS					December 1968		A M	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Calvert County, Md.			U.S.A.						Baltimore Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson 4			St. Joseph Hospital			Homemaker			SHOE OPERATOR		
13a. U.S.A. RESIDENCE (Where deceased lived if institution Residence before admission) STATE Maryland			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
2925 Berwick						Baltimore			2925 Berwick Avenue #34		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
DAVID OGDEN			FLAVILLA ?								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
NO			217-225734			MRS CATHERINE D. STEFANS			2925 BERWICK AVE		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)									48 Hrs		
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Generalized Arteriosclerosis											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
12-14-68			Fracture of Left Hip			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRA-BLING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			12/11/68			Fell out of Bed.					
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21c. LOCATION Street or R.F.D. No City or Town County State					
			Home			2925 Berwick Ave Baltimore 21234					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER						12/21/68		
Charles F. O'Donnell, M.D.											
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR REPOSITORY			23d. LOCATION (City or Town) (County) (State)		
Burial			12-26-1968			Most Holy Redeemer			BALTO. Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
J. Walter Cooper			5444 BELAIR RD.			DEC 30 1968			J. Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16965

16976

1. DECEASED NAME (Type or print) JOHN ALFRED BUTCHER			2a. DATE OF DEATH 12 Month 28 Day 68 Year		2b. HOUR 2:15 PM
3. SEX MALE	4. RACE White	5. DATE OF BIRTH 6/12/1922		6. AGE (In years last birthday) 46 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS M.N.
7a. BIRTHPLACE (State or foreign country) Baltimore Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE Co. Md.		
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREAT. BALT. MED. CEN.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Self Employed	12b. KIND OF BUSINESS OR INDUSTRY Grocer	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY 1b		13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 456 Ilchester Ave	
14. FATHER'S NAME First Middle Last George P. Butcher			15. MOTHER'S MAIDEN NAME First Middle Last Barbara Boehlin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO 215-12-8063	17. INFORMANT Address Margaret M. Butcher Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) EXTENSIVE LIVER METASTASIS 1621 DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA of RIGHT LUNG DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 152A					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 12-10 , 19 68 , to 12-28 , 19 68 , that (I) (we) last saw the deceased alive on December 28, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 12-29-68
22d. PHYSICIAN'S NAME (Type) Dr. Rudiger Breitenedker M.D.				22e. ADDRESS 16701 N. Charles St. 21204	
23a. BURIAL, CREMATION, REINTERMENT Burial	23b. DATE 1/2/69	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. 5305 Harford Road 21214			25a. REC'D BY REGISTRAR DATE DEC 30 1968	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

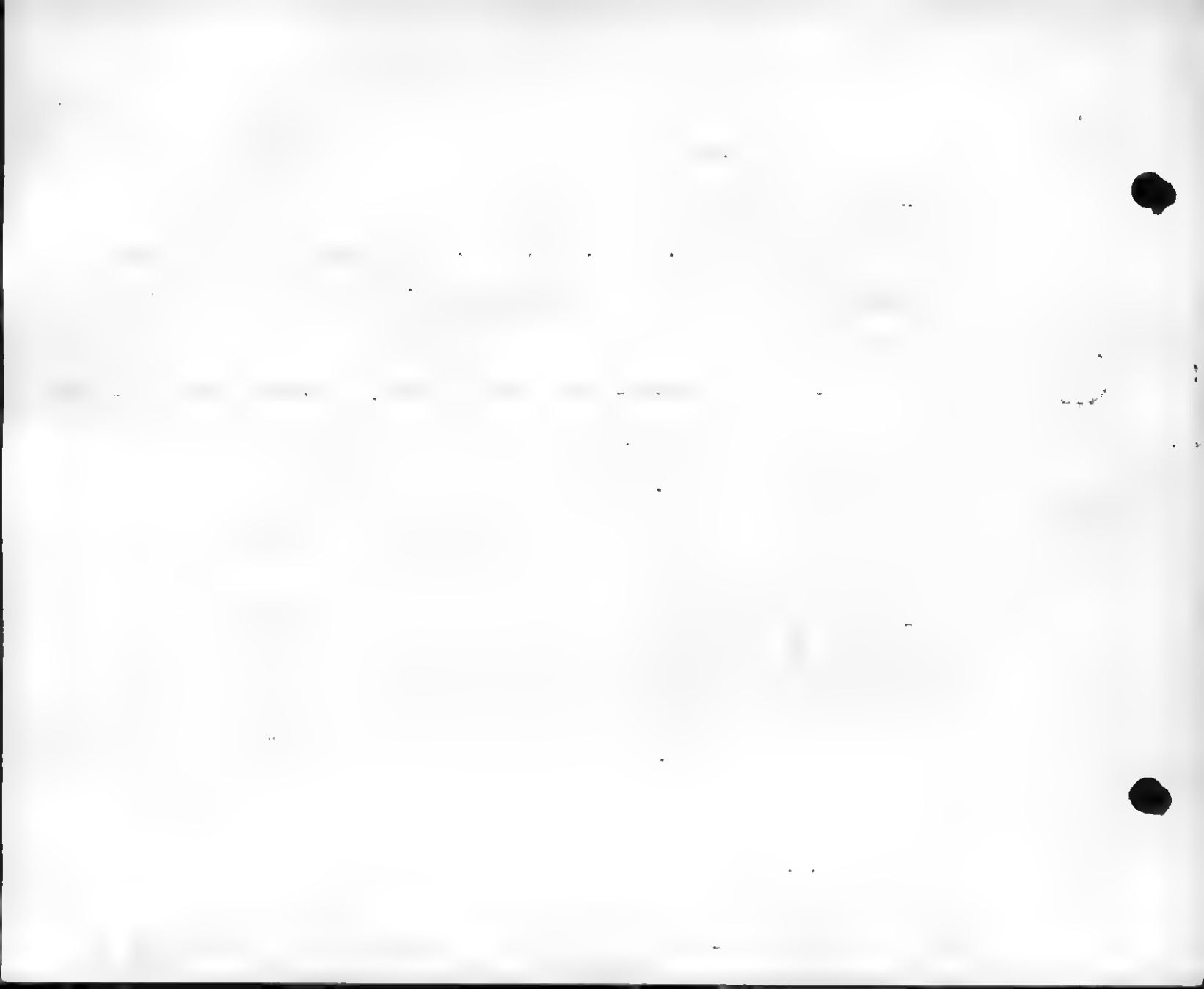


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR A M	
JAMES			NORMAN	BYRD	12 6 68		2:00 M	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
MALE	White		11-12-90		78 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Crisfield, Md.	USA				BALTIMORE Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON		GTR. BALTO. MED. CNTR.		Mgr. Asphalt Div.		Stan. Oil		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5211 Putney Way-12		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
John F. Byrd					Emma Thornton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT Address				
no		092-07-4558		Mrs. Elsie T. Byrd-5211 Putney Way Balto.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE								
1621 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								
(b) COR. PULMONALE								
DUE TO, OR AS A CONSEQUENCE OF								
(c) CA OF LUNGS, LEFT EFFUSION								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
POSSIBLE ADRENAL CRISIS								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
12-5-68		FLUID IN LUNGS			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm street factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 11-20, 1968, to 12-6, 1968, that (I) (we) last saw the deceased alive on 12-6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS		12-6-68		
J.C. AGUILAR				6701 N. CHARLES STREET				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		12/9/68		Druid Ridge Cem.		Balto.		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Mitchell-Wiedefeld Home-6500 York Rd, 21212				DA DEC 13 1968		Charles Judge		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and on any event within 72 hours after death.

Item 10 Film 407
12/18/68 kkk
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
16978

1 DECEASED-NAME (Type or Print) Clarence M. Calp			First Middle Last			2a DATE KNOWN OF ESTI- DEATH MATED December 6, 1968			2b HOUR 7:15 M			
3 SEX Male	4 RACE White	5 DATE OF BIRTH 12/14/05	6 AGE (in years past birthday) 63 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year December 6, 1968			2d HOUR 7:15 M			
7a BIRTH-PLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Balto. co.			Md.			
10 CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Hillendale Contry Club			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Guard			12b KIND OF BUSINESS OR INDUSTRY #11			
13a USUAL RESIDENCE (Where deceased lived, if institution address) STATE Md.			13b COUNTY Balto.		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 808 Powers St.			
14 FATHER'S NAME First Middle Last ?				15. MOTHER'S MAIDEN NAME First Middle Last ?								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes			16b. SOCIAL SECURITY NO. WW11 213-03-6762		17. INFORMANT Elsie I. Calp			ADDRESS 808 Powers St.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (b) General Atherosclerotic DUE TO, OR AS A CONSEQUENCE OF Cardio Renal/Vascular Disease Syst										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION 7/20/68				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK AT HOME <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Charles F. O'Donnell				M.D. 22b. DATE SIGNED 12/16/68				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 12/9/68		23c NAME OF CEMETERY OR CREMATORY Dulaney Valley			23d LOCATION (City or Town) Balto. Co.		(County) (State)		
24 FUNERAL DIRECTOR Paul E. Chenoweth Jr. 3617 Chestnut Ave.						25a REC'D BY REGISTRAR DATE DEC 12 1968		25b REGISTRAR'S SIGNATURE Charles Judge				

1 1/2

FOR STATE
HEALTH DEPT.

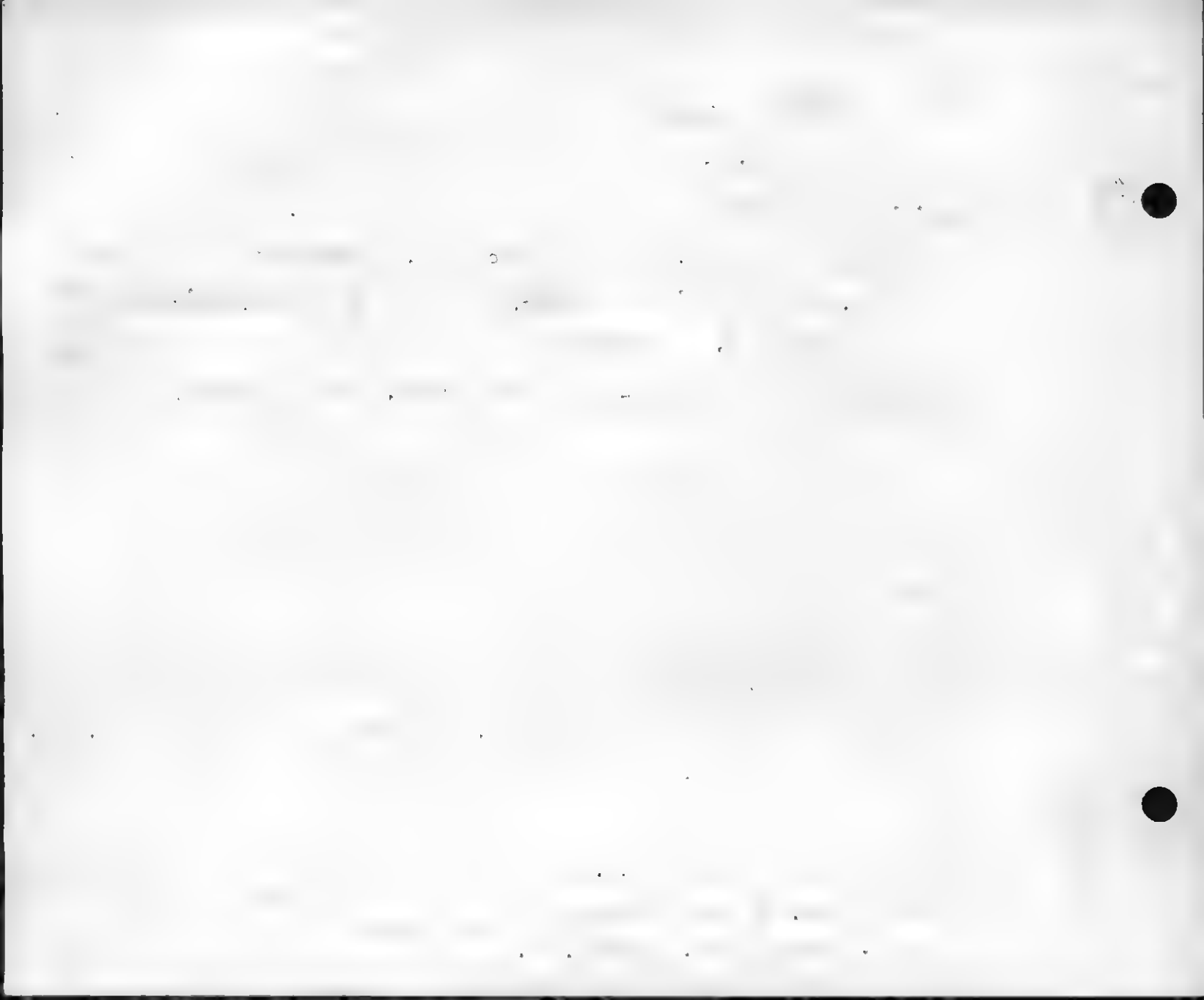
TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16968

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16979

1. DECEASED NAME (Type or Print)		First THOMAS		Middle EDWARD		Last CANTLER		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 12 20 1968			2b. HOUR 2:45 PM	
3 SEX Male	4. RACE white	5. DATE OF BIRTH Oct. 29, 1939	6. AGE (In years last birthday) 29 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year December 20, 1968			2d. HOUR 2:45 PM	
7a. BIRTHPLACE (State or foreign country) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto.						Md.
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rt. 40 & White Marsh Blvd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Assembler				12b. KIND OF BUSINESS OR INDUSTRY auto				
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MD.		13b. COUNTY Harford		13c. CITY OR TOWN Abingdon		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Leight Road, Otter Point				
14. FATHER'S NAME First Middle Last Calvin H. Cantler		15. MOTHER'S MAIDEN NAME First Middle Last Ida Fay Holcomb										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 218-36-1926		17. INFORMANT ADDRESS Folger Brooks, Box 49, Abingdon, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Injuries 129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 2:04 PM 12 20 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Subject in auto-truck collision								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f. LOCATION Street or R.F.D. No Rt. 40 & White Marsh		City or Town Essex		County Balto.		State Md.		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Edward F. Wilson, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 12/20/68		
EXAMINER'S NAME (Type)		ADDRESS (Street, city, town, or county)										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 23, 1968		23c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial Cemetery		23d. LOCATION (City or Town) Abingdon		(County) Harford		(State) Md		
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.		ADDRESS		25. REGISTRAR'S SIGNATURE Charles Young		DATE DEC 23 1968						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item. 7b Film 3408
1/10/69

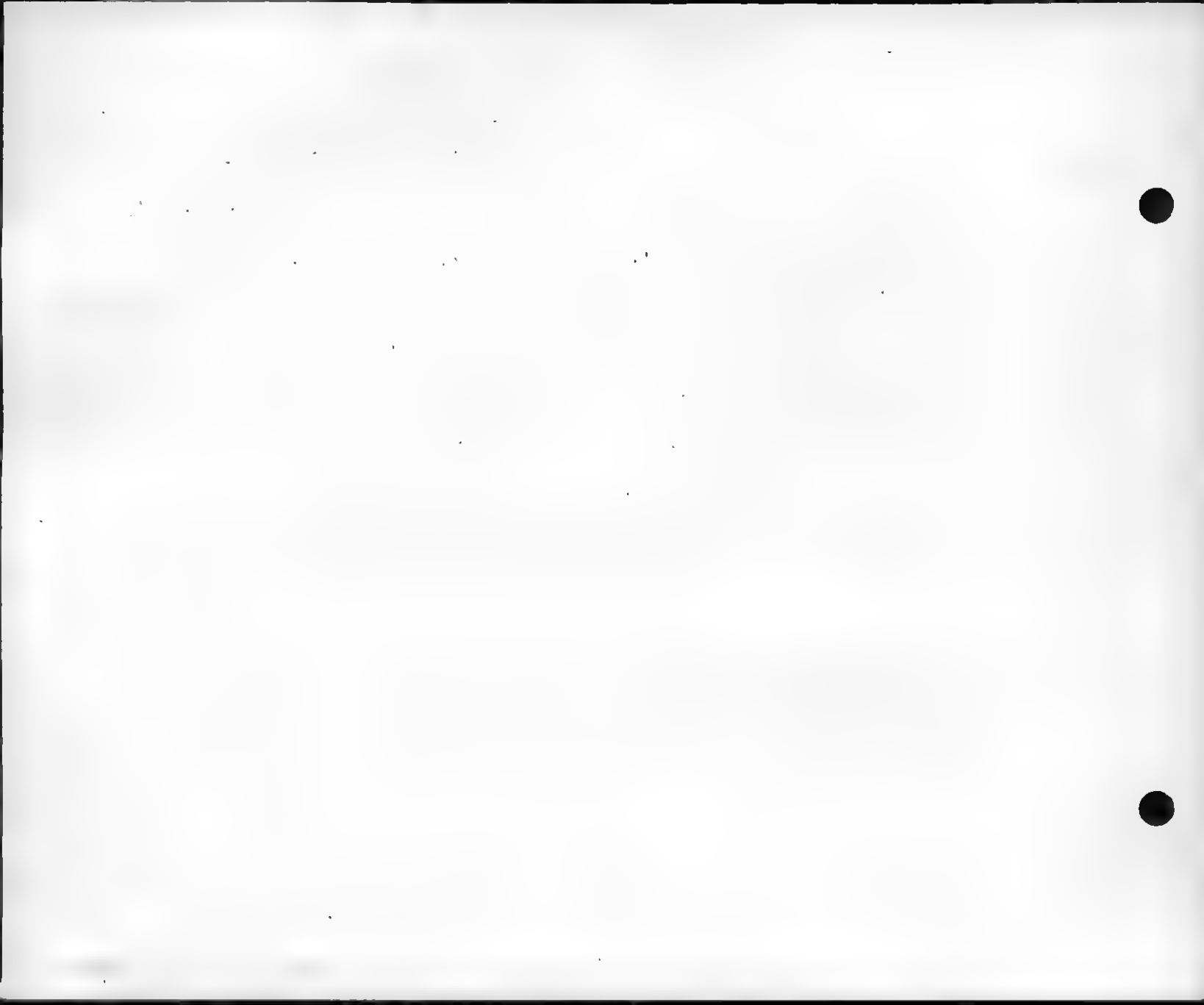
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Stella 16980

CERTIFICATE OF DEATH

16980

1. DECEASED-NAME (Type or print) First Middle Last Stella Carmaggio			2a. DATE OF DEATH Month Day Year 12 23 1968		2b. HOUR M
3 SEX F	4 RACE W	5. DATE OF BIRTH 12-16-1875		6 AGE (In years last birthday) 93 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (State or foreign country) Italy	7b CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Co. Md.		
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Stella Maris Hospice		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3631 E. Kader R.d.
14. FATHER'S NAME First Middle Last Joseph Carmaggio		15. MOTHER'S MAIDEN NAME First Middle Last Rose Carmaggio			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 212-50-3516		17. INFORMANT Mrs. Barbusca Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4104 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD - chronic congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs - Yrs -
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 2 Lee Robbins M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 12/24/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/27/68	23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City or Town) (County) (State) Baltimore Md
24. FUNERAL DIRECTOR Carmino Funeral Home			25a. REC'D BY REGISTRAR DEC 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge



FOR STATE HEALTH DEPT.

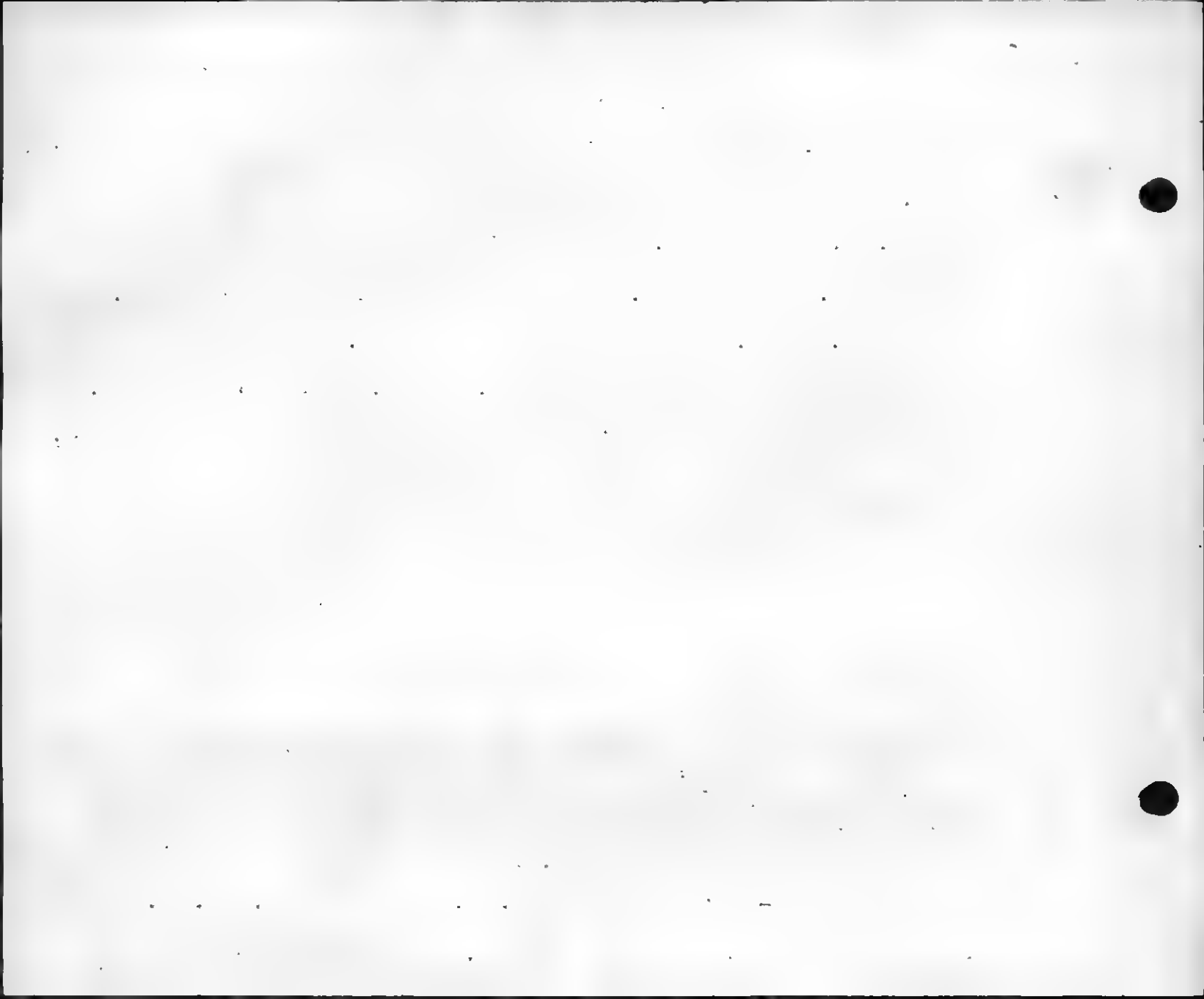
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 19. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16970 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16981

1 DECEASED NAME (Type or Print) Leta Louverta CARR			2a DATE KNOWN OF DEATH Month Day Year December 23 1968			2b HOUR 1:00 PM		
3 SEX Female	4 RACE White	5 DATE OF BIRTH 9-7-98	6 AGE (in years last birthday) 70 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year December 23 1968		
7a BIRTHPLACE (State or foreign country) W. Va		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> D. VORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore		
10 CITY OR TOWN OF DEATH Towson Balto. Co. 21204			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Josephs Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY Home
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b COUNTY Balto.		13c CITY OR TOWN Balto.	3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 2605 Wendover Rd.	
14 FATHER'S NAME First Middle Last Jasper T. Bowers			15 MOTHER'S MAIDEN NAME First Middle Last Lacey N. Maxon					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO (If yes give war or dates of service) 216 23 2641		17 INFORMANT ADDRESS 21234 Mr. Homer H. Carr, 2605 Wendover Rd.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109 Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Approximate interval between onset and death Sudden								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4401								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 12/23/68		
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE 12-26-68		23c NAME OF CEMETERY OR CREMATORY Moreland Me. Pk. Cem		23d LOCATION (City or Town) (County) (State) Balto. Co. Md.		
24. FUNERAL DIRECTOR Johnson Funeral Home, 8521 Loch Raven Blvd.				ADDRESS 21204		25a REC'D BY REGISTRAR DEC 26 1968		25b REGISTRAR'S SIGNATURE Charles Judge



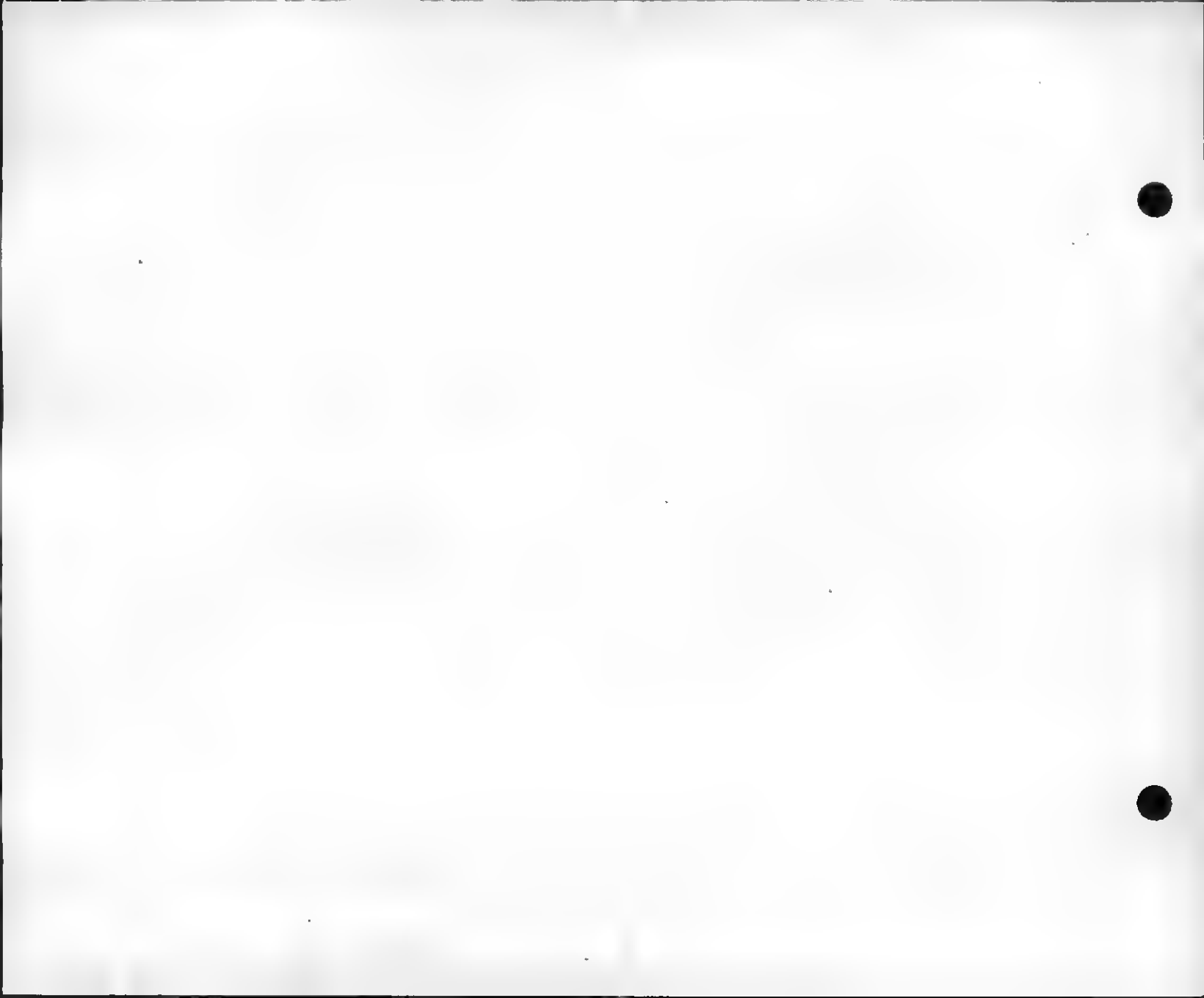
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR		
DANIEL			WALTER			CARROLL			12 29 68 12:30A		
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years lost birthday)		
MALE			WHITE			3/30/90			78 YRS.		
7a BIRTHPLACE (State or foreign)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 COUNTY OF DEATH		
MARYLAND			U.S.A.						BALTIMORE COUNTY Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			2a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
FORT HOWARD			VET. ADM. HOSPITAL			CHAUFFEUR Salesman ret.					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
MARYLAND						BALTIMORE			3438 Levertown Avenue		
14 FATHER'S NAME			15 MOTHER'S M A D E N NAME								
First Middle Last			First Middle Last								
DANIEL H. CARROLL			FRANCES E. KELLY								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war and dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT			Address		
YES			WW I			218 09 22 45			CLIN. RECORDS, VA HOSP. FT HOWARD, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u>										RECENT	
4124 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										OLD	
(b) <u>PULMONARY EMPHYSEMA</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>ARTERIOSCLEROTIC HEART DISEASED, MARKED</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
12.0 BENIGN PROSTATIC HYPERTROPHY											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d INJURY OCCURRED			21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f LOCATION			City or Town County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No					
22a I certify that (X) (this hospital) attended the deceased from 12/21/68, 19 to 12/29/68, 19, that (X) (we) lost the deceased alive on 12/29/68, 19, and that in (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death.											
22b SIGNATURE			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c DATE SIGNED		
PETER V. JUVAN									12/30/68		
22d PHYSICIAN'S NAME (Type)			22e ADDRESS								
PETER V. JUVAN, M. D.			VAH FORT HOWARD, MARYLAND								
23a BURIAL, CREMATION, EMBALM (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
BURIAL			1/2/69			BALTIMORE NATIONAL Cemetery			BALTIMORE, MARYLAND		
24 FUNERAL DIRECTOR			ADDRESS			25a REF. BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
			MORAN FUNERAL HOME			JAN 2 1969			J. Charles Judge		
			42nd & Greenmo			BALTO. MD.					

MEDICAL CERTIFICATION

VMD 154 69



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

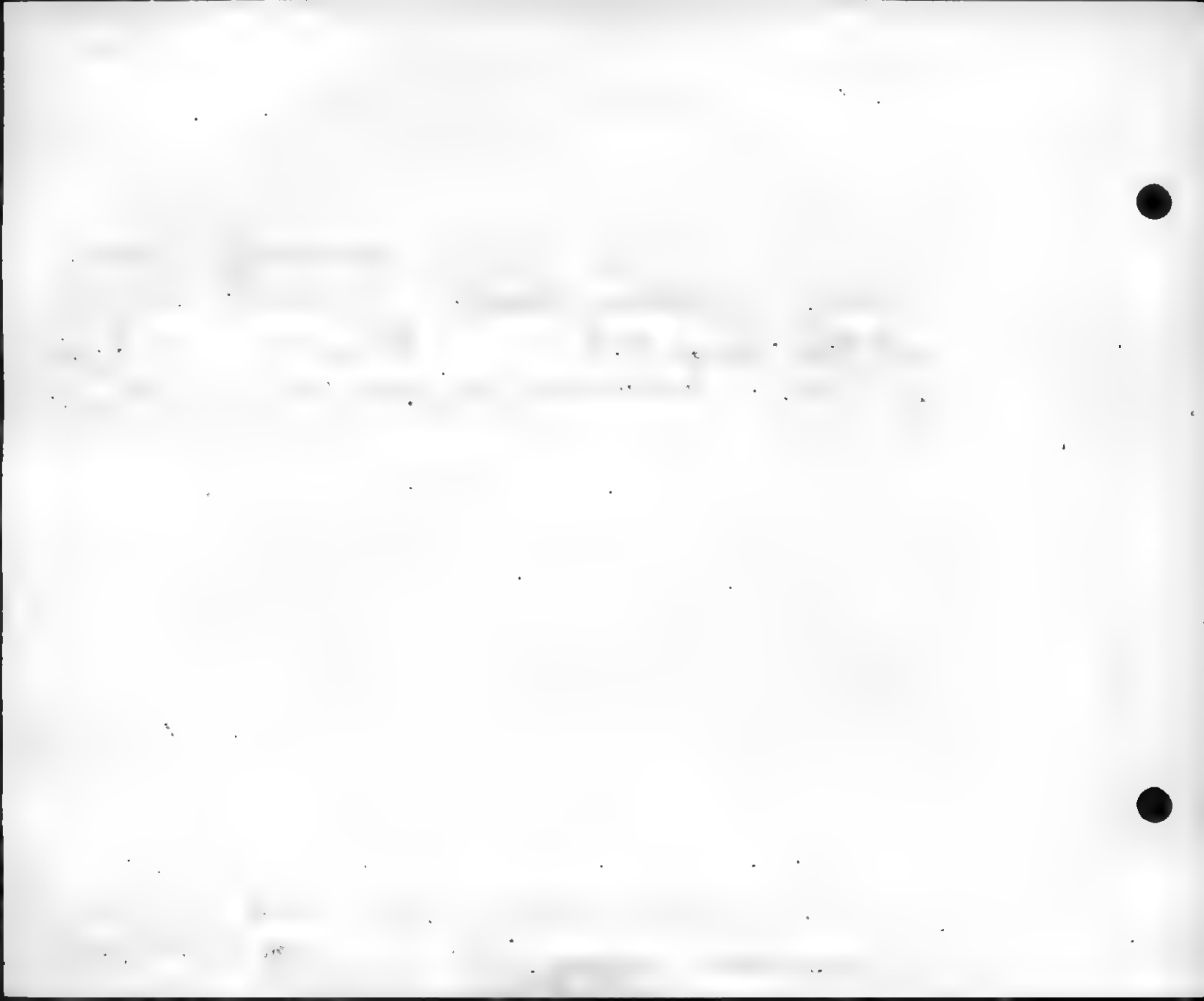
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16972

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16983

1. DECEASED-NAME (Type or print) First Middle Last WILSON HENRY CARTER			2a. DATE OF DEATH Month Day Year 12 18 68			2b. HOUR 5 AM	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH JAN 3, 1911		6. AGE (In years last birthday) 57 YRS.	
7a. BIRTHPLACE (State or foreign country) BALTO. MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SHANGRI-LA Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Building Insp.		12b. KIND OF BUSINESS OR INDUSTRY Telephone Central	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Pikesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Smith Ave		14. FATHER'S NAME First Middle Last William Henry Carter		15. MOTHER'S MAIDEN NAME First Middle Last Rebecca Winks			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. 179-01-1898		17. INFORMANT Miss Betty Rose Carter		Address Pikesville, Md.	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS							
DUE TO, OR AS A CONSEQUENCE OF (b) GENERALIZED ARTERIO SCLEROSIS							
DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC PARKINSONISM							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly med. cal examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 9-15, 1968 , to 12-17, 1968 , that (I) (we) last saw the deceased alive on 12-13, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Samuel P. Scalia, M.D.				22c. DATE SIGNED 12-18-68			
22d. PHYSICIAN'S NAME (Type) SAMUEL P. SCALIA, M.D.				22e. ADDRESS 2 SHERWOOD AVE. BALTO., MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 20, 1968		23c. NAME OF CEMETERY OR CREMATORY Mount Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Pikesville Baltimore Md.	
24. FUNERAL DIRECTOR Burwell Funeral Home		25a. RECEIVED BY REGISTRAR DEC 19 1968		25b. REGISTRAR'S SIGNATURE Charles J. J...			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

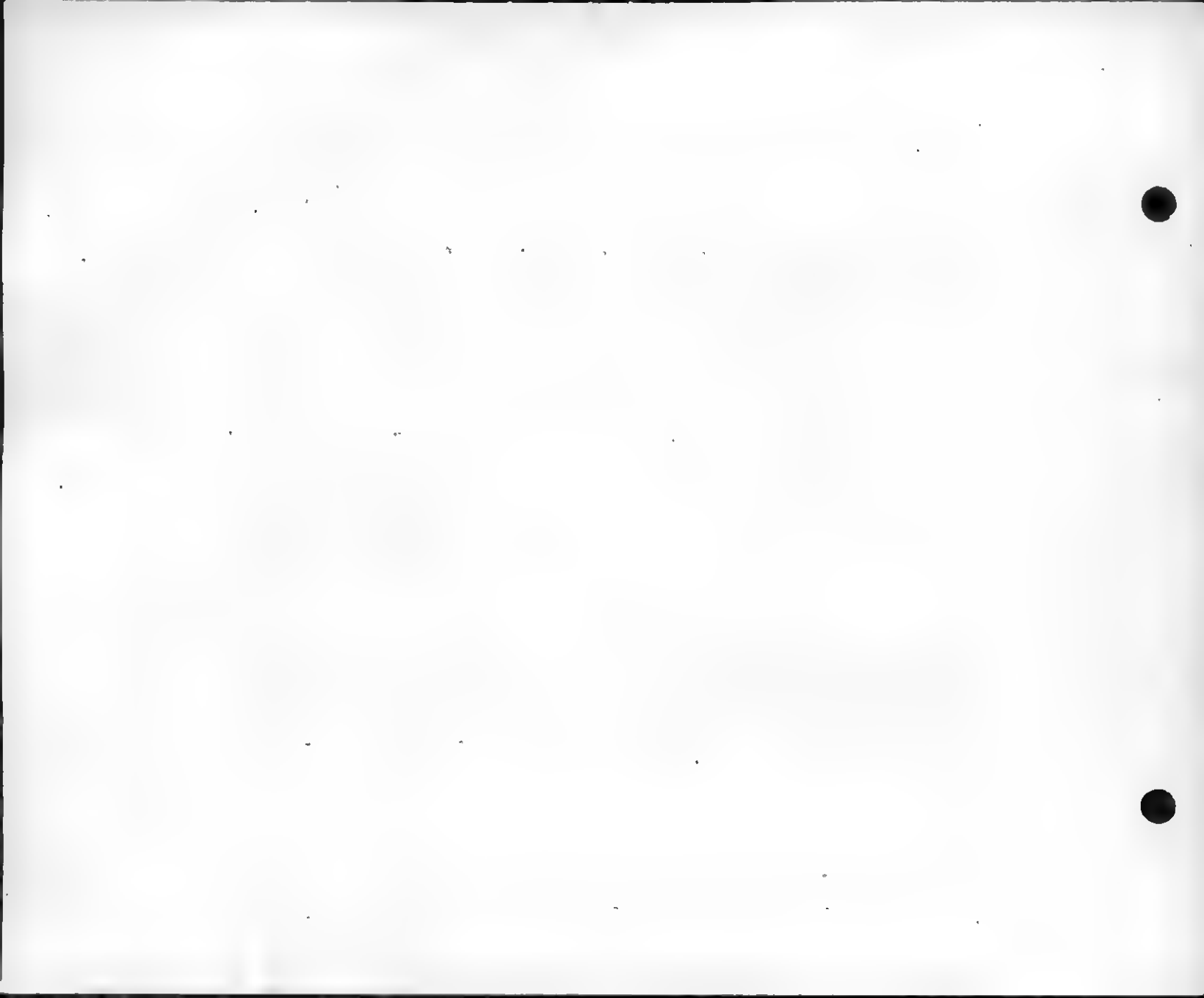
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16973

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16984

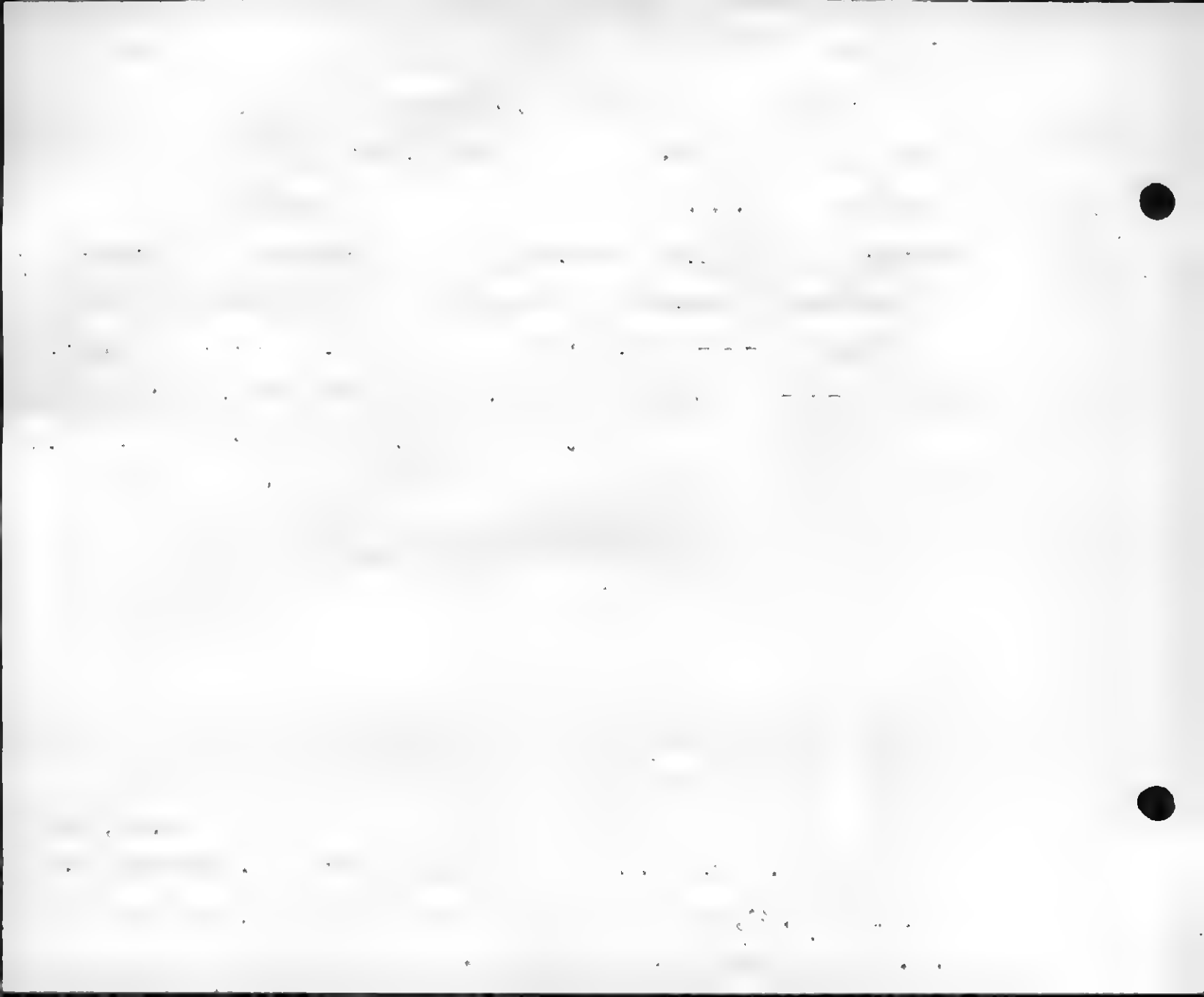
1. DECEASED-NAME (Type or print) LEO			First Middle Last			2a. DATE OF DEATH DEC. Month 23 Day 68 Year			2b. HOUR 2P M			
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH June 17, 1900			6. AGE (In years last birthday) 68 YRS			
7a. BIRTHPLACE (State or foreign country) W. Va.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE Md.			
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital street address) GR. HAITO. MED. CENTER			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY Railroad			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Parkville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET AND NUMBER 2601 Taylor Ave.			14. FATHER'S NAME First Eston Middle Cave Last Cave			15. MOTHER'S MAIDEN NAME First Sallie Middle Bowers Last Bowers						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT Mrs. Alice M. Cave, 2601 Taylor Ave.			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RETROPERITONEAL CA WITH METASTASIS 1580 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19 1968 P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from DEC. 20 , 19 68 to DEC 23 , 19 68 , that (I) (we) last saw the deceased alive on DEC. 23 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Mary Li			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 12-23-68			
22d. PHYSICIAN'S NAME (Type) DR. MARY LIM			22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE Dec. 27, 1968			23c. NAME OF CEMETERY OR CREMATORY Moreland Memo. Park			23d. LOCATION (City or Town) (County) (State) Parkville, Md.			
24. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road.			ADDRESS			25a. REC'D BY REGISTRAR DEC 30 1968			25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR		
William Joseph Chamberlain						December 18 1968		9 ³⁰ A M		
3. SEX		4. RACE		5. DATE OF BIRTH		6 AGE (n years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS		
Male		Cauc.		June 28, 1890		78 YRS.				
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Baltimore Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Baltimore			8324 Wyton Road			Electrician		Electrical		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Baltimore		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8324 Wyton Road	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Joseph - - - Chamberlain			Matilda - - - Fretwell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT Address					
NO			213 03 3436A		Mrs. Patricia Zeiler 8324 Wyton Road 21204					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>									<u>Sudden</u>	
4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Arteriosclerotic CVD</u>									<u>1 yr.</u>	
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
<u>Diabetes mellitus</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
22. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 19</u> , 19 <u>68</u> , to <u>Dec 18</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 17</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Joseph F. LiPira M.D.</u>					22c. DATE SIGNED <u>Dec. 20, 1968</u>					
22d. PHYSICIAN'S NAME (Type) <u>Joseph F. LiPira M.D.</u>					22e. ADDRESS <u>8400 Loch Raven Blvd. Baltimore, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
<u>Burial</u>		<u>Dec. 21, 1968</u>		<u>New Cathedral Cemetery</u>		<u>Baltimore, Maryland</u>				
24. FUNERAL DIRECTOR <u>J. E. Lowell Lemmon</u>					25a. REC'D BY REGISTRAR DATE <u>DEC 23 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			
<u>4611 Park Heights Ave.</u>										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16975
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH
16986

1 DECEASED NAME (Type or print) First Middle Last Mary V. Chiariello			2a DATE OF DEATH Month Day Year 12-18-68			2b HOUR 8:30 P.M.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH 2-2-1889		6 AGE (in years lost birthday) 79 YRS	
7a BIRTHPLACE (State or foreign country) Italy		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.	
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 613 Crosby Road		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) At Home		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET AND NUMBER 613 Crosby Road 21207		14 FATHER'S NAME First Middle Last Gatano		15 MOTHER'S MAIDEN NAME First Middle Last Theresa Martino			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b SOCIAL SECURITY NO.		17 INFORMANT Address Vivian Bunch-613 Crosby Road 21207			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A.S.C.V.D</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs years.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from <u>11/4/1968</u> , to <u>12/11/1968</u> , that (I) (we) last saw the deceased alive on <u>11/16/1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (view) the body after death.							
22b SIGNATURE <u>Adnan M. Sonmez</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 12/19/68	
22d PHYSICIAN'S NAME (Type) ADNAN M. SONMEZ		22e ADDRESS 1011 Frederick Rd. MD 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-23-68		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Pikesville, Maryland	
24 FUNERAL DIRECTOR Ellsworth Armacost-4600 Liberty Hghts Ave.				25a REC'D BY REGISTRAR DATE DEC 20 1968		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) SARAH ^{First} or SARA ^{Middle} ROBERTA ^{Last} CIRINCIONE			2a DATE OF DEATH 12 ^{Month} 23 ^{Day} 68 ^{Year}			2b HOUR 8:40 ^A M			
3. SEX FEMALE		4 RACE white		5. DATE OF BIRTH 5/23/15		6. AGE (In years last birthday) 53 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN	
7a BIRTHPLACE (State or foreign country) Taneytown Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md			
10 CITY OR TOWN OF DEATH BALTIMORE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GR. BALTO. MED. CENTER		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Machine Opr. Crown, Cork &		12b KIND OF BUSINESS OR INDUSTRY Seal			
13a USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE Md.		13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 3319 Brendan Ave.	
14 FATHER'S NAME ^{First} Charles W. ^{Middle} Young ^{Last}			15. MOTHER'S MAIDEN NAME ^{First} Sara ^{Middle} Fringer ^{Last}						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (Unknown) <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT ^{Address} John Cirincione, husband, above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 1579 IMMEDIATE CAUSE (a) UPPER GI BLEEDING DUE TO, OR AS A CONSEQUENCE OF CARCINOMA OF PANCREAS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1578									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. 19 Month 12 Day 23 Year 68 P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No 6701 N. CHARLES ST. City or Town BALTIMORE County BALTIMORE State MD					
22a. I certify that the (this hospital) attended the deceased from 12/23/68 to 12/23/68 , that (I) (we) lost saw the deceased alive on 12/23/68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE BEN F. HUGHES, M.D.					DEGREE MD ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/23/68		
22d. PHYSICIAN'S NAME (Type) BEN F. HUGHES MD.					22e. ADDRESS 6701 N. CHARLES ST.				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 12/26/68		23c. NAME OF CEMETERY OR CREMATORY Taneytown Luth. Cem.		23d LOCATION (City or Town) (County) (State) Taneytown, Md.			
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane					25a. REC'D BY REGISTRAR DEC 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

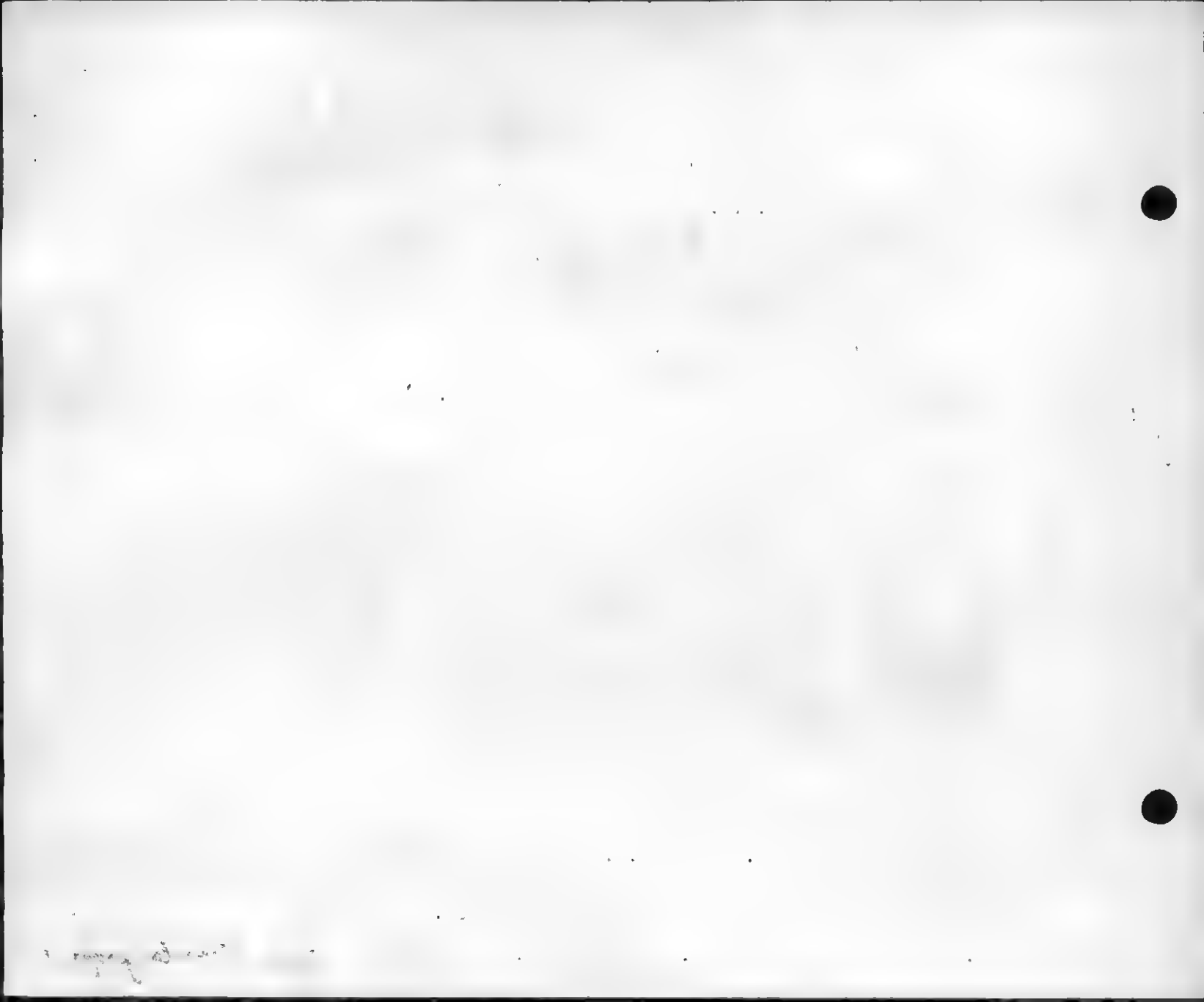
Items 18-22a Film 408 Maryland State Department of Health
1-3-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16977

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16988

1 DECEASED NAME (Type or Print) First Middle Last CATHERINE L CLARK			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12/30 1968			2b HOUR 7:30 P.M.	
3 SEX female	4 RACE white	5 DATE OF BIRTH April 17, 1919	6 AGE (In years last birthday) 49 YRS	7 UNDER 1 YEAR MONTHS DAYS 0 0	7 UNDER 24 HRS HOURS MIN. 0 0	2c DATE PRONOUNCED DEAD Month Day Year December 30, 1968	
7a BIRTHPLACE (State or foreign country) Maryland		7b CIT ZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore	
10 CITY OR TOWN OF DEATH Lutherville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 209 Ridgely Rd.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b CITY Baltimore		13c CITY OR TOWN Lutherville		3d INS DE CITY & HTS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET AND NUMBER 209 Ridgely Road		14 FATHER'S NAME First Middle Last Otto Lissau		15 MOTHER'S MAIDEN NAME First Middle Last Margaret Whyte			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO (If yes give war or dates of service) 215-07-2747		17 INFORMANT James B. Clark		ADDRESS Same as # 13 E	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fatty Liver/ Barbiturate overdose							
DUE TO, OR AS A CONSEQUENCE OF (b) 9500							
DUE TO, OR AS A CONSEQUENCE OF (c) 9702							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION 12/30/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 ALTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 2:00 P.M. 12/30/68		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Subject ingested an overdose of drugs			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f LOCATION Street or R.F.D. No. City or Town Lutherville		County State Baltimore Md.	
22a. I certify that I took charge of the remains described above, held on P Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz		M.D. Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED 12/31/68	
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE 1-4-69		23c NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem.		23d LOCATION (City or Town) (County) (State) Cockeysville Md.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson Inc.				ADDRESS Towson, Md. 21204		25a REC'D BY REGISTRAR JAN 3 1969	
				25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Mary		Clark		Clark		Clark		Month December Day 18 Year 1968		2:25 P.M.	
3 SEX		4 RACE		5 DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
female		white		Dec. 18, 1898		70 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				Md.	
Penna.		U. S.				Baltimore					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Catonsville		SPRING GROVE STATE HOSP.		factory worker							
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Md.				Balto.				117 South Conkling			
14 FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
James Clark		Clark		Clark		Clark		Sarah Burns		Burns	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		Address			
				216-07-1844-A		Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Pneumonia Rt Lung											
486 X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year									
		P.M. 19									
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f LOCATION Street or R.F.D. No City or Town County State							
22a I certify that (a) (this hospital) attended the deceased from Aug. 22 1968, to Dec. 18 1968, that (I) (we) last saw the deceased alive on Dec. 18 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE		22c DATE SIGNED		22d PHYSICIAN'S NAME (Type)		22e ADDRESS					
Dionidis E. Pirovolidis		12-18-68		Dionidis Pirovolidis, M.D.		SPRING GROVE STATE HOSPITAL		Baltimore, Maryland 21228			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial		12/21/68		SACRED HEART CEM.		13A H & M.					
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
B. D. ADAMS		214 E. B. & H. ST.		DEC 24 1968		Charles Judge					



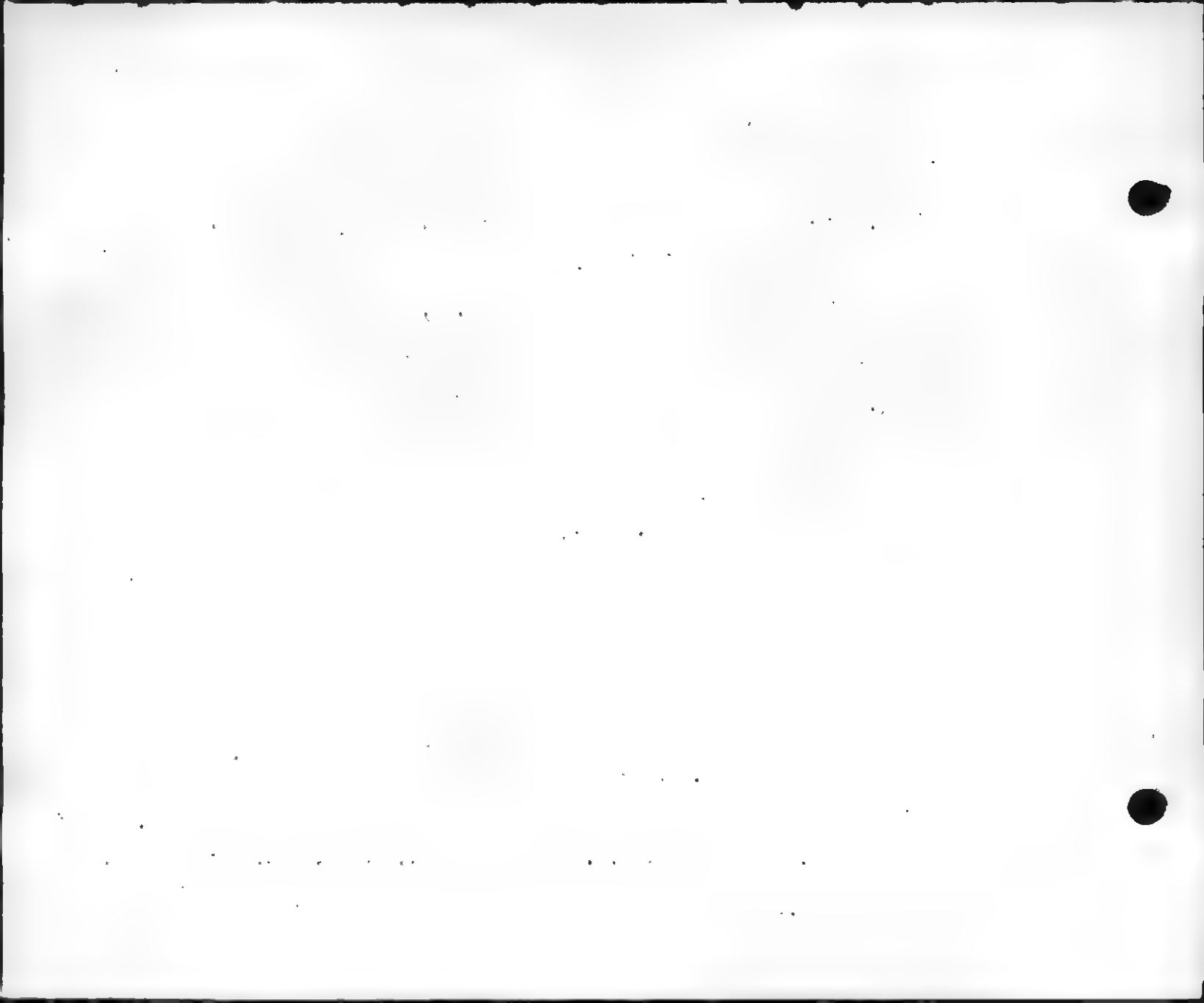
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16990

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>407 W. Pennsylvania Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Marie</u> Last <u>Cockey</u>		4. DATE OF DEATH Month <u>December</u> Day <u>4</u> Year <u>1968</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 8, 1884</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew J. Leutz</u>		14. MOTHER'S MAIDEN NAME <u>Lillie Hood</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Family records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO VASCULAR ACCIDENT</u> <u>4-7-68</u> DUE TO (b) <u>GENERALIZED ARTERIO SCLEROSIS</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>9/25/62</u> , 19 <u> </u> , to <u>Dec. 4, 1968</u> , that (I) <u>did not</u> saw the deceased alive on <u>Dec. 3, 1968</u> , and that death occurred at <u>10:15 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>T. C. Siwinski</u>		22b. DATE SIGNED M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>Dec. 6, 1968</u>	
22c. PHYSICIAN'S NAME (Type) <u>T. C. Siwinski, M.D.</u>		22d. ADDRESS <u>206 W. Penna. Ave., Towson, Md. 21204</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 7, 1968</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 9 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1/68

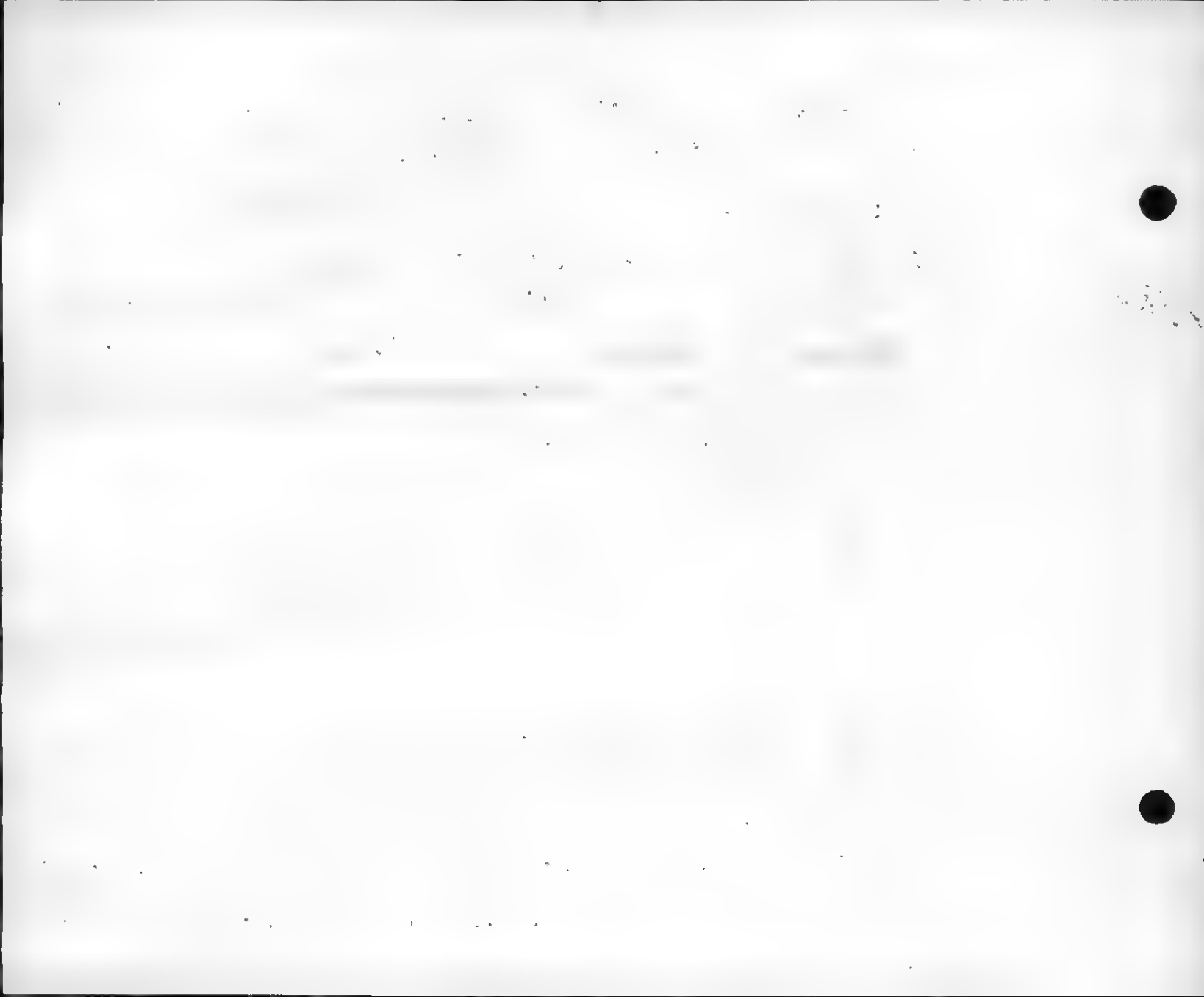
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16980

CERTIFICATE OF DEATH

16991

1. DECEASED NAME (Type or print) <i>Bertha Estelle Corant</i>			2a. DATE OF DEATH Month <i>12</i> Day <i>28</i> Year <i>68</i>			2b. HOUR <i>11:15</i> AM			
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>July 27, 1898</i>		6. AGE (In years last birthday) <i>70</i> YRS		IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Balto. Co. Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md			
10. CITY OR TOWN OF DEATH <i>Cockeysville, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Marion Home, Md.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Shoe</i>		12b. KIND OF BUSINESS OR INDUSTRY —			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4304 Grandview Ave.</i>	
14. FATHER'S NAME First <i>Thomas</i> Middle <i>-</i> Last <i>Sparger</i>			15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>-</i> Last <i>Leves</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (or unknown) <i>no</i>		16b. SOCIAL SECURITY NO <i>215-05-3517</i>		17. INFORMANT Address <i>Renda M. Marion Home, Cockeysville</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerosis Vas. Dis.</i> <i>4409</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>41</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____					
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec. 1</i> , 1968, to <i>Dec. 3</i> , 1968, that (I) (we) last saw the deceased alive on <i>Dec. 3</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Carl F. Benson md</i> DEGREE _____ ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <i>Dec. 3, 1968</i>			
22d. PHYSICIAN'S NAME (Type) <i>Carl F. Benson md</i>						22e. ADDRESS <i>5111 York Rd. Balto Md 21212</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-5-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>			
24. FUNERAL DIRECTOR <i>Wm Cook-Brooks Towson</i>		ADDRESS <i>1050 York Rd Towson Md 21204</i>		25a. REC'D BY REGISTRAR <i>REG 1</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>1968</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

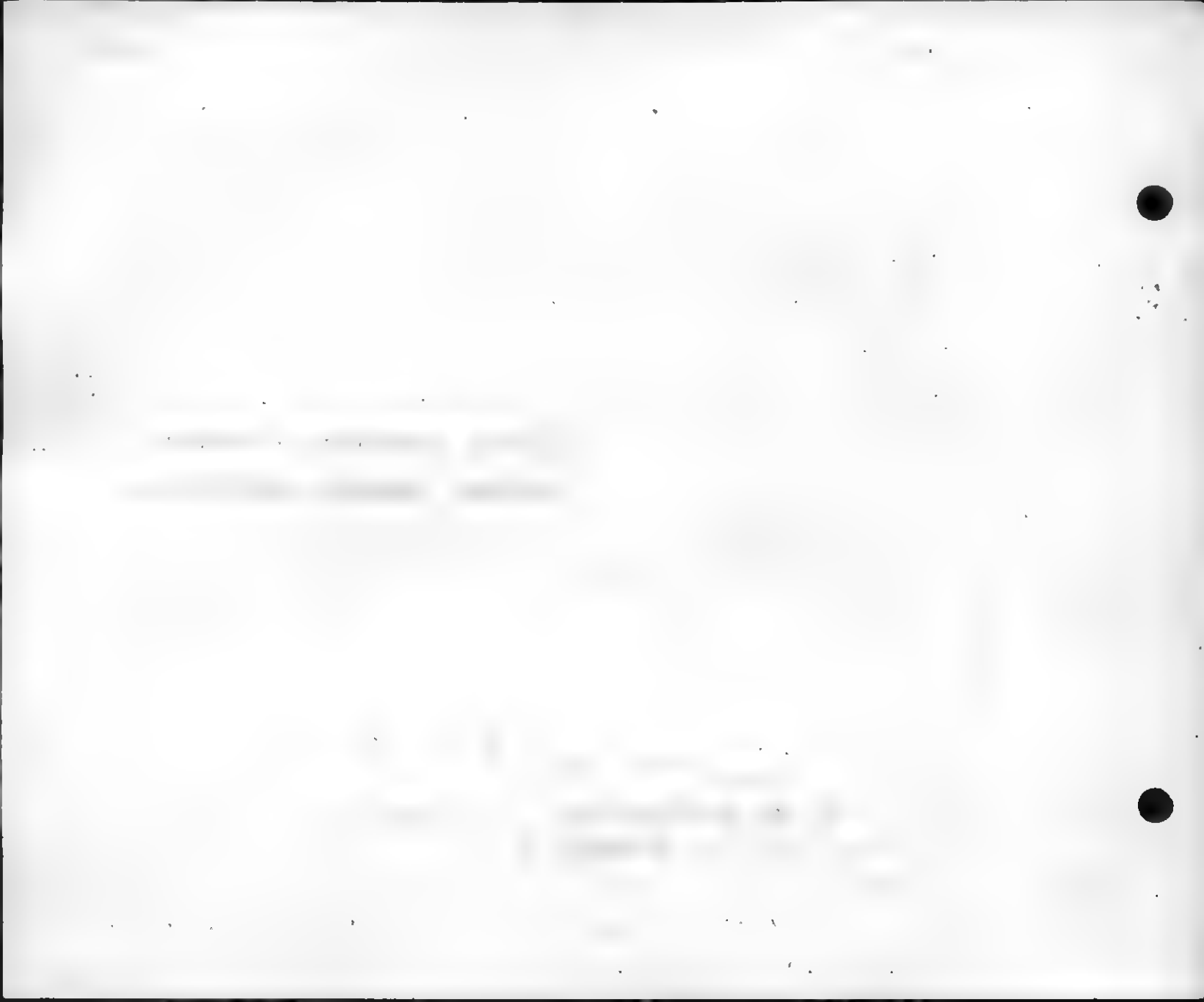
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16981

16992

1. DECEASED-NAME (Type or print) Anita Carlyle Cooper			2a. DATE OF DEATH Month 12 Day 3 Year 1968			2b. HOUR P. 1:30 M		
3. SEX female		4. RACE white		5. DATE OF BIRTH 12/23/1893		6. AGE (In years last birthday) 74 YRS		
7a. BIRTHPLACE (State or foreign country) Bermuda		7b. CITIZEN OF WHAT COUNTRY? Bermuda		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Towson, Maryland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dulaney Towson Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Bermuda			13b. COUNTY Southampton		13c. CITY OR TOWN Petersfield		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last J.D. Carlisle Darrell			15. MOTHER'S MAIDEN NAME First Middle Last ????? Hollis			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no		
16b. SOCIAL SECURITY NO. -----			17. INFORMANT Dulaney Towson Nursing Home			Address 111 West Road		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro-vascular accident DUE TO, OR AS A CONSEQUENCE OF (b) Cerebro-vascular arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) ----- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. -----							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 2211								
19a. DATE OF OPERATION -----		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -----		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -----		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) -----				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, off-office building, etc.) -----		21f. LOCATION Street or R.F.D. No. City or Town County State -----		22a. I certify that (I) (this hospital) attended the deceased from 8-8-1966 to 12-3-1968 , that (I) (we) last saw the deceased alive on 12-2-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		
22b. SIGNATURE Keith A. Manley			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 12-3-68		
22d. PHYSICIAN'S NAME (Type) KEITH A. MANLEY			22e. ADDRESS -----					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-7-1968		23c. NAME OF CEMETERY OR CREMATORY Bailey's Bay Cem.		23d. LOCATION (City or Town) (County) (State) Hamilton Parish, Bermuda		
24. FUNERAL DIRECTOR Perinchief Fun. Home, West Hamilton, Bermuda			ADDRESS -----		25a. REC'D BY REGISTRAR DATE DEC 5 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

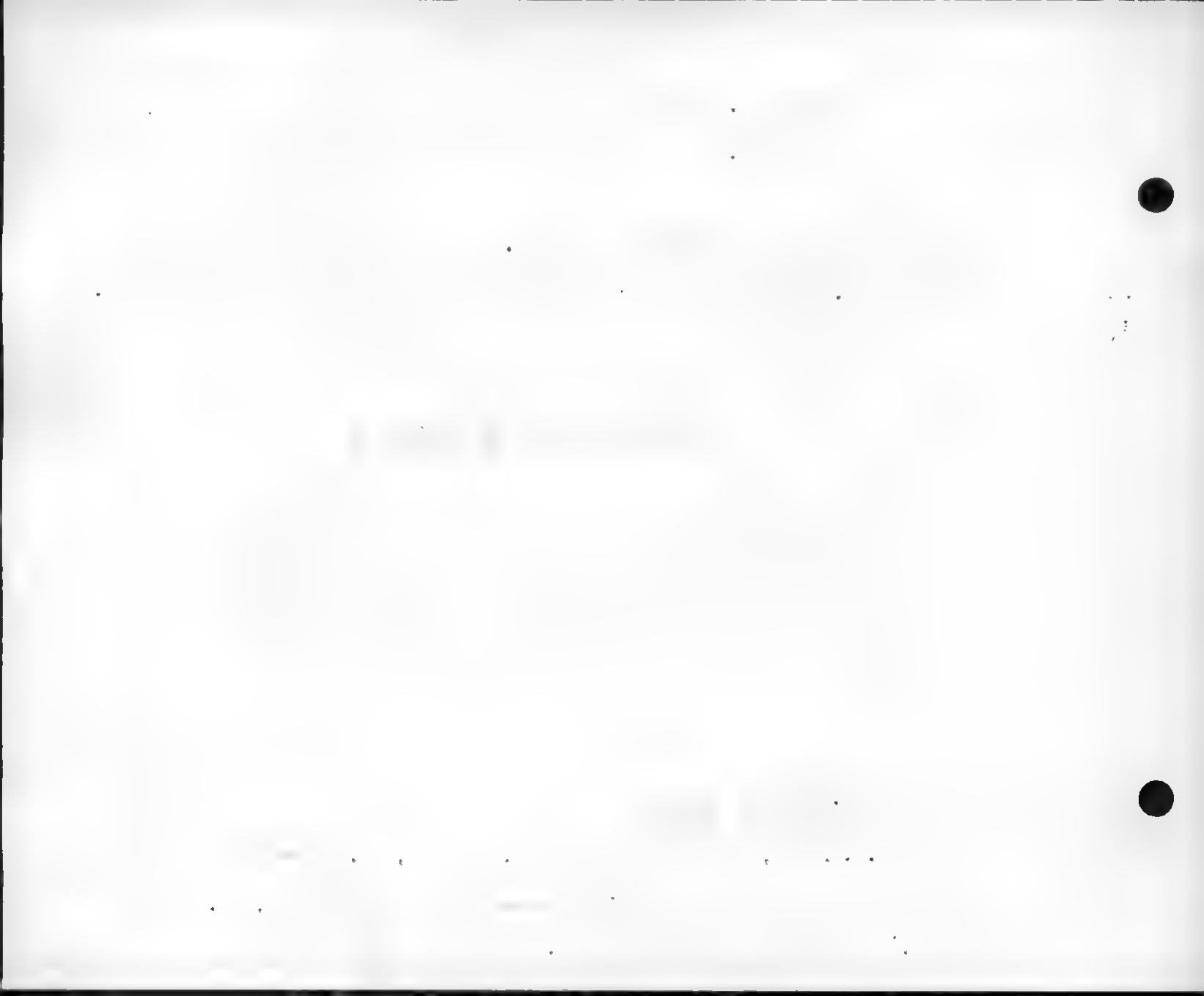


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parenthesis in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR		
Ernest S. Cooper						Month Day Year		Hour		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR	8 UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		2d HOUR		
Male	White	Sept. 24, 1901	67 YRS	MONTHS DAYS HOURS MIN		Month Day Year		Hour		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED NEVER MARRIED WIDOWED DIVORCED		9 COUNTY OF DEATH				
Maryland		USA				Baltimore				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
Middle River 21220		55 "B" Oak Grove Dr.		Driver		Trucking				
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Md.			Baltimore		Middle River		YES NO		55 "B" Oak Grove Dr.	
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last						
John Cooper				Mary Gray						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No			212 09 3829		Joseph Holter		Same			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-C-U-Disease</u>										
4129 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c) DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
4221										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
							YES NO			
21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH			21b TIME OF INJURY Month Day Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
			19							
21d INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			M.B. Davis			CHIEF MEDICAL EXAMINER		22b DATE SIGNED		
								12/9/68		
EXAMINER'S NAME (Type)			M.B. Davis, MD			DEPUTY MEDICAL EXAMINER				
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)		
Burial		12/11/68		Baltimore Cemetery		Baltimore, Md.				
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
James E. Bruzdziński				1407 Eastern Ave. 21221		DEC 12 1968		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

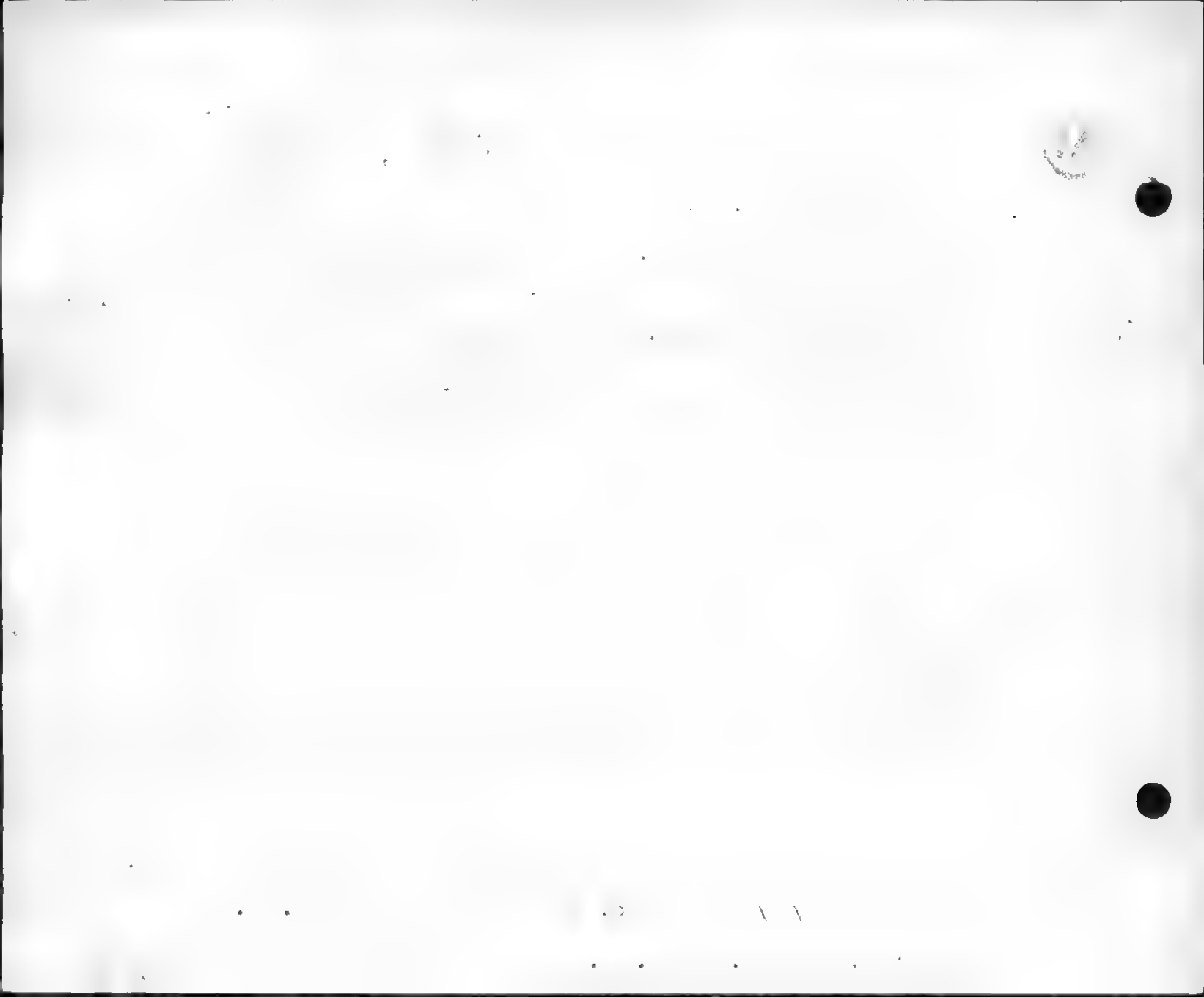
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

169883

16994

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month <u>December</u> Day <u>25</u> , Year <u>1968</u>		2b. HOUR <u>1:30</u>		
ROSE		CORAM							
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH <u>January 20, 1892</u>			6 AGE (In years lost birthday) <u>76</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country) MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE		Md			
10 CITY OR TOWN OF DEATH TOWSON		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b COUNTY BALTIMORE		13c CITY OR TOWN BALTIMORE		13d INS. OF CITY, MD. 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1210 WOODBOURNE AVE. #21212	
14 FATHER'S NAME First Samuel		Middle Leonard		Last Bridget		15 MOTHER'S MAIDEN NAME First Bridget		Middle Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b SOCIAL SECURITY NO (If yes give war or dates of service)		17 INFORMANT Rose Adelson		Address same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive intestinal infarction</u> <u>4442</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>702</u>									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, B.U., DINING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from <u>December 22 19 68</u> , to <u>December 25 19 68</u> , that (X) (we) last saw the deceased alive on <u>December 25, 19 68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>William</u>		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED <u>12-25-68</u>			
22d PHYSICIAN'S NAME (Type) Ines Gilliani, M.D.		22e ADDRESS 7620 York Road, Towson, Md. 21204							
23a BURIAL, CREMATION, REBURY (Type) <u>Burial</u>		23b DATE <u>12/28/68</u>		23c NAME OF CEMETERY OR CREMATORY Loudon Park		23d LOCATION (City or Town) (County) (State) Balto. Md.			
24 FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.		ADDRESS		25a REC'D BY REG. STRAR DATE <u>DEC 26 1968</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 10 Filed 1/8/69
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
1/8/69 kk 16995

1. DECEASED-NAME (Type or Print) KIMBERLY ANN CORBETT			2a. DATE KNOWN OF DEATH Month 12 Day 26 Year 1968		2b. HOUR M
3 SEX Female	4. RACE White	5. DATE OF BIRTH Eight 6 weeks	6. AGE (In years last birthday) 2	IF UNDER 1 YEAR MONTHS 2 DAYS 	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE
10. CITY OR TOWN OF DEATH Baynesville		11. NAME OF HOSPITAL OR INSTITUTION (If none, give street address) Bend Drive 8700 Apt. D Loch Raven Blvd.		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Child	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Bend Drive 8700 Apt. D Loch Raven Blvd.
14. FATHER'S NAME First Middle Last Thomas Reid Corbett			15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Mae Weatherman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS Thomas R. Corbett, 8700 Loch Bend Drive 21204	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 381.9 Bilateral otitis media (SDII) IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) 					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate		M.D. Charles S. Springate, M.D.		22b. DATE SIGNED December 26, 1968	
EXAMINER'S NAME (Type)		ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)	
Burial	12-28-68	Moreland Md. Pk Cemetery		Balto. Co. Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REG. STR.	25b. REG. STR.'S SIGNATURE
William E. Johnson		8521 Loch Raven Blvd. 21204		DEC 30 1968	Charles Judge





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

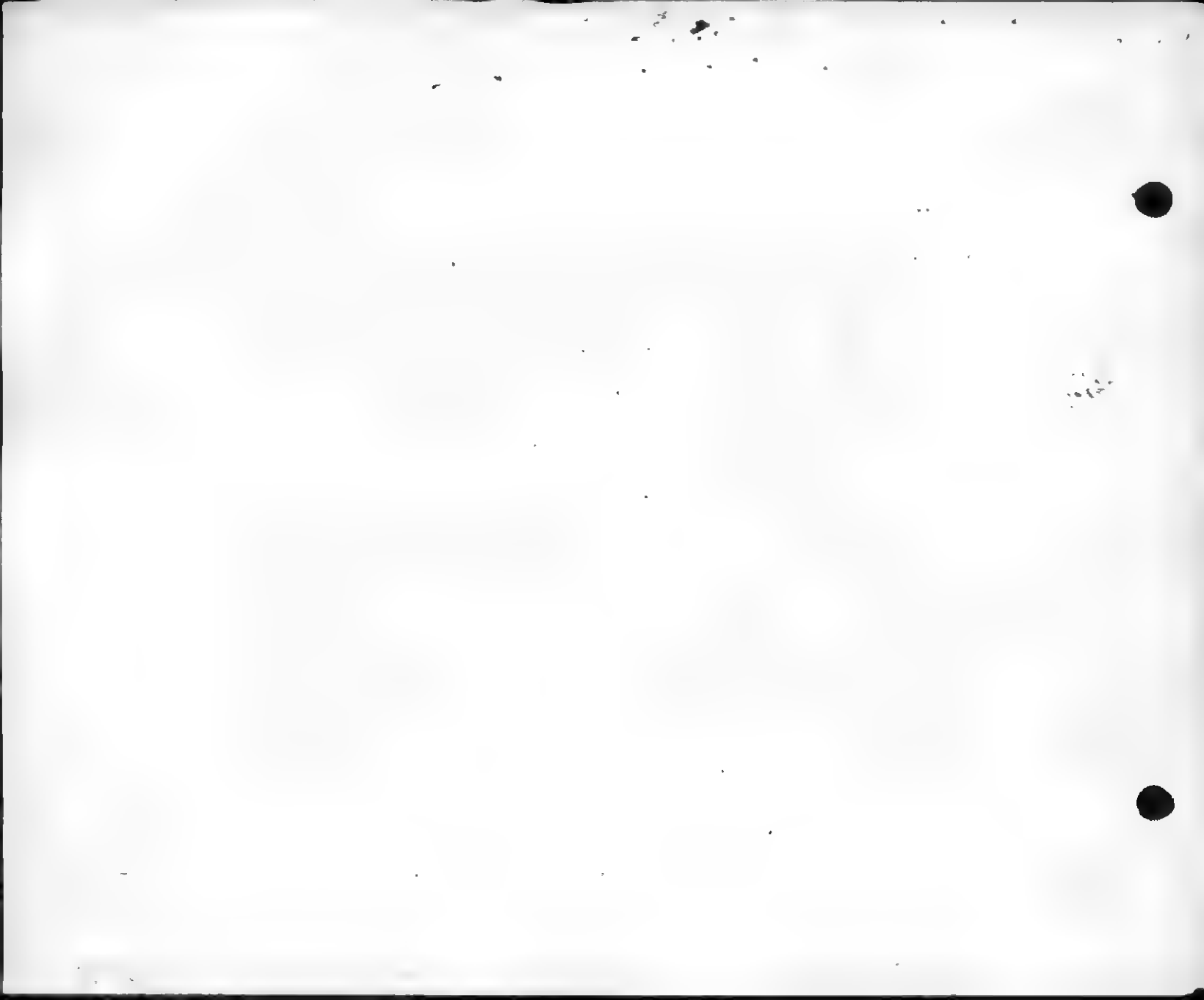
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16996

CERTIFICATE OF DEATH

16997

1 DECEASED-NAME (Type or print)		First PAUL		Middle CHARLES		Last CORNELIUS SR.		2a. DATE OF DEATH Month Day Year DECEMBER 7, 1968			2b. HOUR 1:10 P.M.	
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH JULY 12, 1920			6 AGE (In years last birthday) 48 YRS.		7 UNDER YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE			Md			
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (If give street address) HOSPITAL VETERANS ADMINISTRATION		12a. USUAL OCCUPATION (Kind of work done during most of working life, even retired) TRUCK DRIVER			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUA. RES DENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		3d. INS. OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3313 RAVENWOOD AVENUE				
14. FATHER'S NAME First Middle Last HIRAM CORNELIUS		15. MOTHER'S MAIDEN NAME First Middle Last FLORENCE STAHL										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) YES WWII		16b. SOCIAL SECURITY NO. 170 12 6027		17 INFORMANT CLINICAL RECORDS, VAH FT HOWARD, MD Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHIAL PNEUMONIA, MASSIVE 4127 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), (b) MULTIPLE PULMONARY EMBOLI stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) MYOCARDIAL INFARCTION WITH MURAL THROMBOSIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS WEEKS YEARS												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm street factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (X) (this hospital) attended the deceased from 11/6/68, 19__, to 12/7/68 19__, that (X) (we) last saw the deceased alive on 12/7/68 19__, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.												
22b. SIGNATURE 		DEGREE ATTENDING PHYS		<input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 12 8 68						
22d. PHYSICIAN'S NAME (Type) MARIO QUIROS, M.D.		22e. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND										
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12/12/68		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND						
24. FUNERAL DIRECTOR MORAN FUNERAL HOME, 3000 E BALTO ST, BALTO, MD		25a. REC'D BY REGISTRAR DATE DEC 11 1968		25b. REGISTRAR'S SIGNATURE 								



DEC 23 1968

Field
12/23/68 in
(already noted
before by
J. Jones)

To Whom It May Concern
I Mrs Betty C. Cornelius wife
of Paul Charles Cornelius Sr. who
died on Dec. 7-1968 at Fort Howard
Hospital in Baltimore County do
not wish to have any Certificate
of death given to anyone under
any circumstances what so ever.

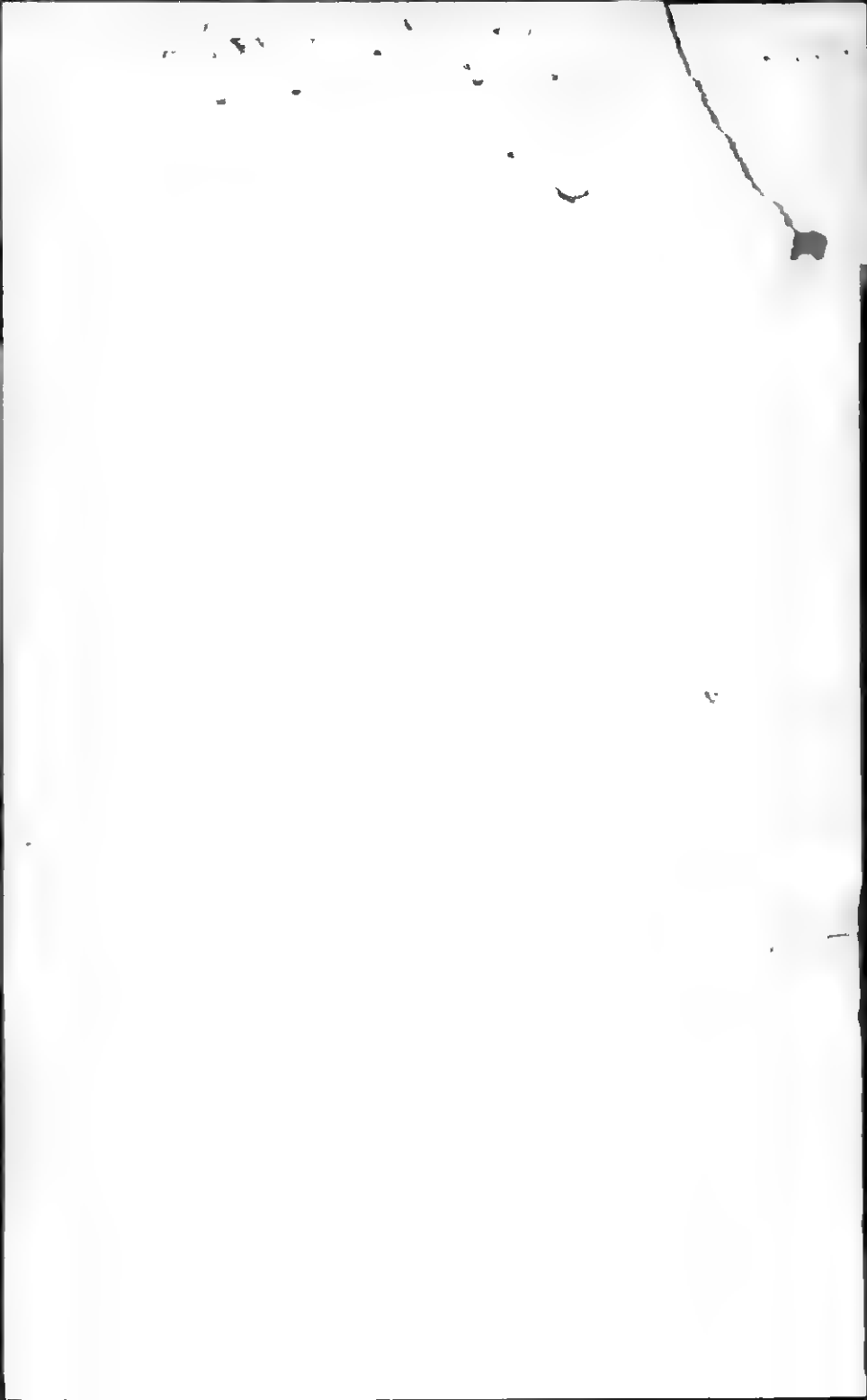
Thank You Very Much

Mrs Betty C. Cornelius

1629 Gail Road Apt 2

Baltimore 21221

Maryland.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1043. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or Print)			First Fred.		Middle S.		Last Corson			2a DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year 12 25 1968		2b HOUR 8:25 AM	
3 SEX Male		4 RACE W.		5 DATE OF BIRTH 3-15-1907		6 AGE (In years last birthday) 61 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year 12 25 19 68		2d HOUR 8:25 AM	
7a BIRTHPLACE (State or foreign country) Va.				7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto.				Md	
10 CITY OR TOWN OF DEATH Towson XXX 21212				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6900 Lackland Cir				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Chief Eng.				12b KIND OF BUSINESS OR INDUSTRY Merch. Marine	
13a USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) STATE Md.				13b COUNTY Balto.		13c CITY OR TOWN Towson 21212		3d INS. OF CITY, STATE, & NATS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 6900 Lackland Cir.			
14 FATHER'S NAME First Middle Last Fred S. Corson, Sr.					15 MOTHER'S MAIDEN NAME First Middle Last Maude Bryant								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b SOCIAL SECURITY NO. 217-16-4328		17. INFORMANT Dorothy H. Corson				ADDRESS same as 13 above			
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion Sudden DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Coronary Artery Disease 5+y DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part or Part 2, Item 18)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Charles F. O'Donnell, M.D.				CHIEF MED. CAL. EXAMINER <input type="checkbox"/>				ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>		DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 12-25-1968	
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.				ADDRESS (Street, city, town, or county) 7501 York Rd.									
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE 12-28-1968		23c NAME OF CEMETERY OR CREMATORY Woodlawn				23d LOCATION (City or Town) (County) (State) Balto., Md.					
24 FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Inc. Towson, Md. 21204				ADDRESS 1050 X York Rd.		25a REC'D BY REGISTRAR DEC 30 1968		25b REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

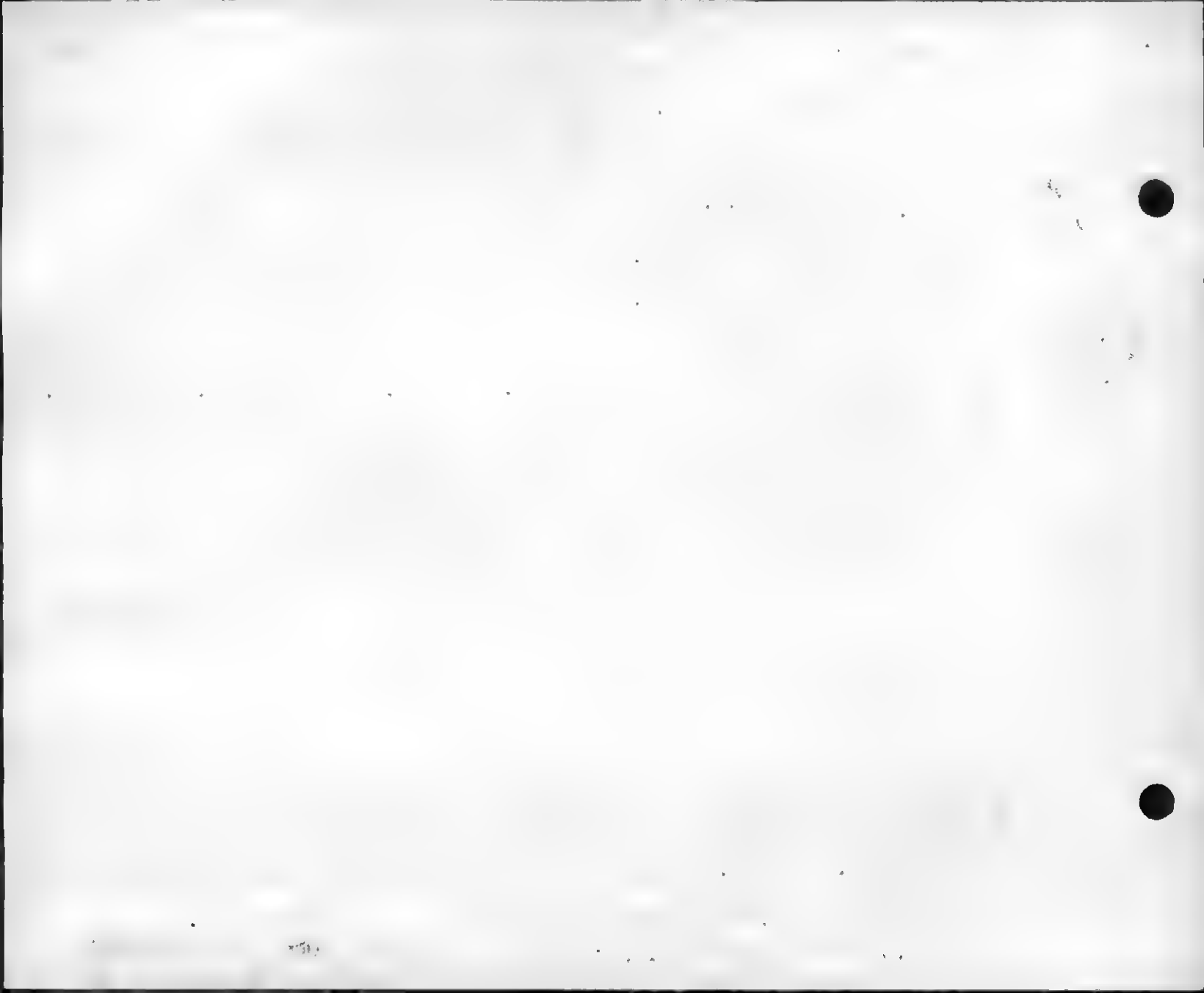
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16998

CERTIFICATE OF DEATH

16999

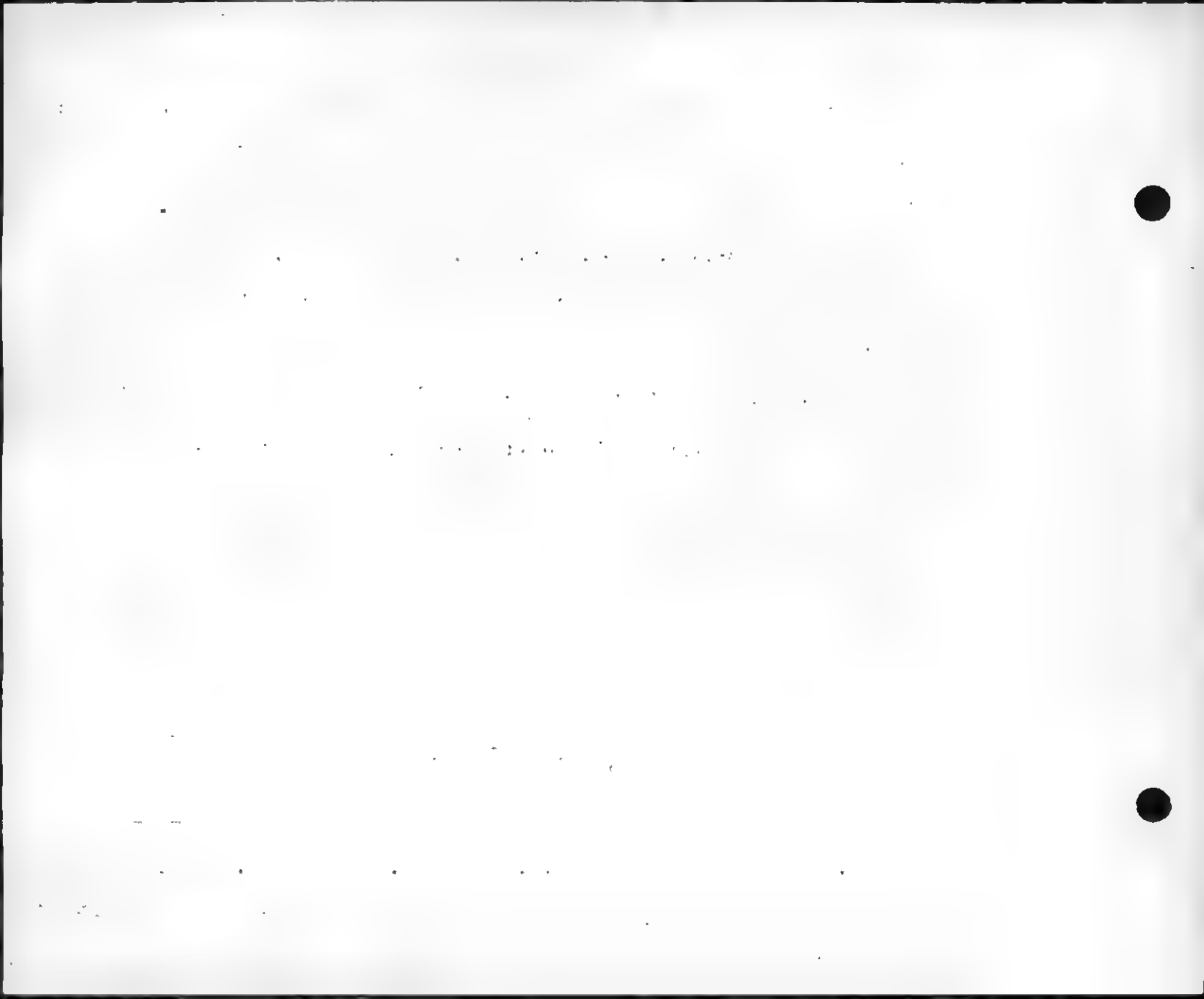
1 DECEASED-NAME (Type or print) Eugenia E. Cost			2a. DATE OF DEATH Month December Day 9 Year 1968			2b. HOUR 6:15 PM			
3 SEX Female		4. RACE White		5. DATE OF BIRTH 7/5/96		6 AGE (in years lost birthday) 72 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS M.N.	
7a BIRTHPLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			
10 CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 24 N. Belgrove Rd			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b COUNTY Balto.		13c CITY OR TOWN Catonsville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 24 N. Belgrove Road 21228	
14. FATHER'S NAME First Middle Last George Snyder			15. MOTHER'S MAIDEN NAME First Middle Last Eleanore Rabbitt						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no, or Unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Horace F. Cost, Sr., 24 N. Belgrove Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) coronary atherosclerosis & chronic heart failure DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) none								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate several years	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from 29 Jan. 1966 to 9 Dec. 1968 , that (I) (we) last saw the deceased alive on 10 Oct 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE W. K. Gallager, Jr. M.D.				22c. DATE SIGNED 10 Dec 68					
22d. PHYSICIAN'S NAME (Type) Dr. Wilmer K. Gallager, Jr				22e. ADDRESS 6630 Baltimore National Pike					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/10/68		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Witzke, 4101 Edmonds Avenue, 21229				25a. REC'D BY REGISTRAR DEC 11 1968		25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div>16989</div> <div> <div>17000</div> <div> <div>1</div> <div>10</div> </div> </div>											
<div> <div>1. DECEASED-NAME (Type or print)</div> <div>First</div> <div>BERT</div> <div>Middle</div> <div>RIDDELL</div> <div>Last</div> <div>CRAMER</div> </div>							<div>2a. DATE OF DEATH</div> <div>12 Month 27 Day 68 Year</div>		<div>2b. HOUR</div> <div>8:45 PM</div>		
<div>3. SEX</div> <div>MALE</div>		<div>4. RACE</div> <div>WHITE</div>		<div>5. DATE OF BIRTH</div> <div>10/17/19</div>		<div>6. AGE (In years last birthday)</div> <div>49 YRS</div>		<div>IF UNDER 1 YEAR</div> <div>MONTHS DAYS</div>		<div>IF UNDER 24 HRS</div> <div>HOURS MIN</div>	
<div>7a. BIRTHPLACE (State or foreign country)</div> <div>Maryland</div>		<div>7b. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div>		<div>8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div>9. COUNTY OF DEATH</div> <div>BALTIMORE Co. Md.</div>					
<div>10. CITY OR TOWN OF DEATH</div> <div>TOWSON</div>			<div>11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</div> <div>GREAT. BALT. MED. GEN.</div>			<div>12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)</div> <div>Ass't. General Fore-Beth.Steel</div>			<div>12b. KIND OF BUSINESS OR INDUSTRY</div>		
<div>13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE</div> <div>Maryland</div>			<div>13b. COUNTY</div> <div>—</div>		<div>13c. CITY OR TOWN</div> <div>Baltimore</div>		<div>13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div>		<div>13e. STREET AND NUMBER</div> <div>2916 Alvarado Sq.</div>		
<div>14. FATHER'S NAME</div> <div>First</div> <div>Bert</div> <div>Middle</div> <div>Riddell</div> <div>Last</div> <div>Cramer</div>				<div>15. MOTHER'S MAIDEN NAME</div> <div>First</div> <div>Margaret</div> <div>Middle</div> <div>—</div> <div>Last</div> <div>Bromwell</div>							
<div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown</div> <div>Yes</div>				<div>16b. SOCIAL SECURITY NO.</div> <div>217-14-5474</div>		<div>17. INFORMANT</div> <div>Address</div> <div>Viola Cramer-2916 Alvarado Sq.</div>					
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART 1. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) <u>Bowel Malignancy; COLON CANCER (Chronic)</u></div> <div>1538</div> <div>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</div> <div>(b) _____</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> <div>(c) _____</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div>										<div>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div>	
<div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</div> <div>1538</div>											
<div>19a. DATE OF OPERATION</div>			<div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</div>			<div>20a. AUTOPSY?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>		<div>20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</div>			
<div>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)</div>			<div>21b. TIME OF INJURY</div> <div>HOUR A.M. Month Day Year</div> <div>P.M. 19</div>		<div>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)</div>						
<div>21d. INJURY OCCURRED</div> <div>While <input type="checkbox"/> Not while <input type="checkbox"/></div> <div>at work <input type="checkbox"/> at work <input type="checkbox"/></div>			<div>21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)</div>			<div>21f. LOCATION</div> <div>Street or R.F.D. No. City or Town County State</div>					
<div>22a. I certify that (A) (this hospital) attended the deceased from <u>11-28</u>, 19<u>68</u>, to <u>12-27</u>, 19<u>68</u>, that (B) (we) lost saw the deceased alive on <u>December 27</u>, 19<u>68</u>, and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) <u>not</u> view the body after death.</div>											
<div>22b. SIGNATURE</div> <div><i>Dr. Morteza</i></div> <div>DEGREE</div>						<div>ATTENDING PHYS.</div> <div><input type="checkbox"/></div>		<div>MED. DIRECTOR</div> <div><input type="checkbox"/></div>		<div>STAFF PHYS.</div> <div><input checked="" type="checkbox"/></div>	
<div>22c. DATE SIGNED</div> <div>12-27-68</div>											
<div>22d. PHYSICIAN'S NAME (Type)</div> <div>DR. MORTEZA MOUSSAVI, M.D.</div>						<div>22e. ADDRESS</div> <div>6701 N. Charles St. 21204</div>					
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div>			<div>23b. DATE</div> <div>12/30/68</div>		<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Gardens of Faith Cem.</div>			<div>23d. LOCATION (City or Town) (County) (State)</div> <div>Baltimore Maryland</div>			
<div>24. FUNERAL DIRECTOR</div> <div>ADDRESS</div> <div>Robert C. Altenburg Funeral Home Inc.</div> <div>6009 Harford Rd. - Balto., Md. 21214</div>						<div>25a. REC'D BY REGISTRAR</div> <div>DATE DEC 30 1968</div>		<div>25b. REGISTRAR'S SIGNATURE</div> <div><i>J. Charles Judge</i></div>			



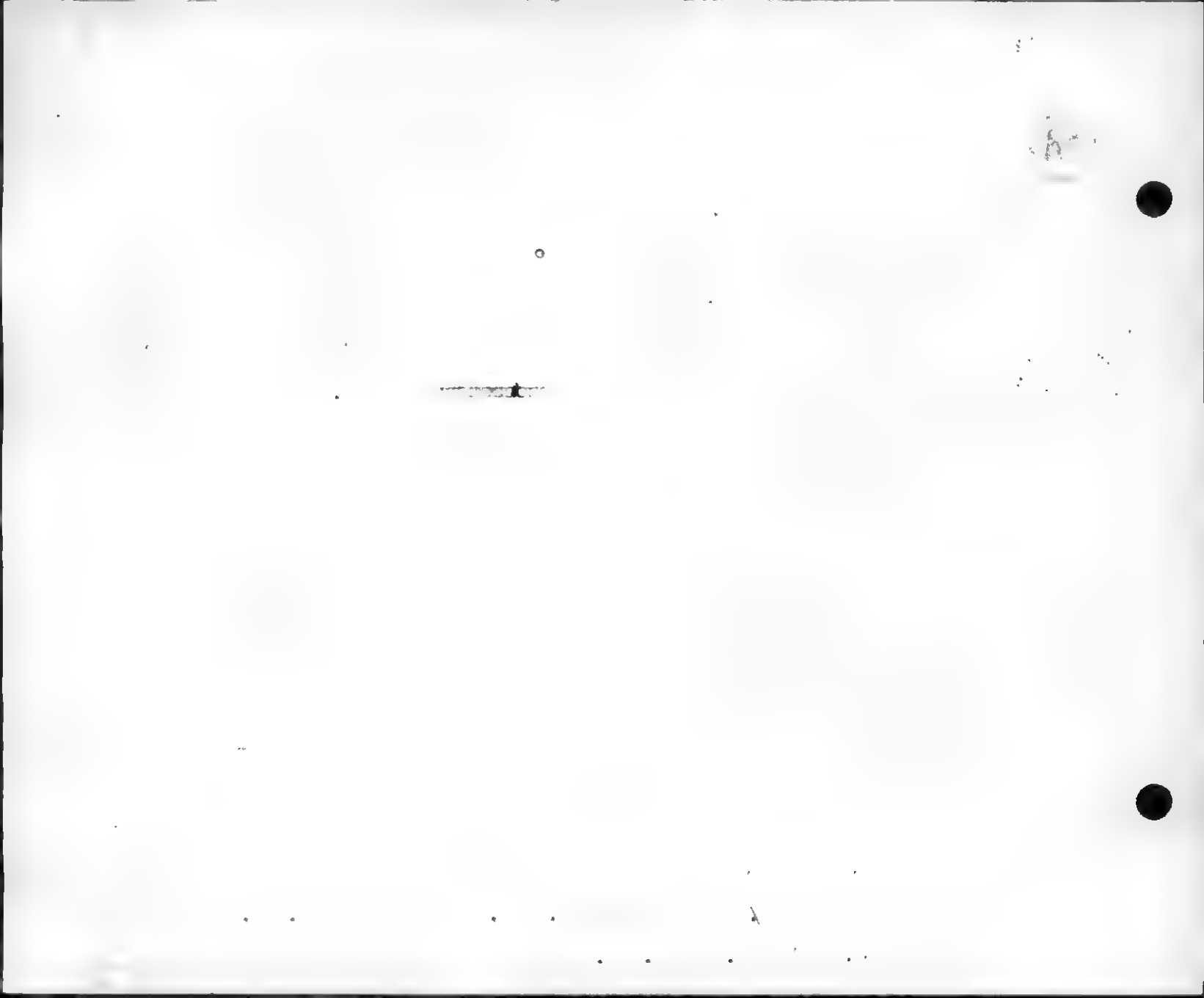
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1 X

16990										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17001																																							
1. DECEASED-NAME (Type or print)										First Middle Last										2a. DATE OF DEATH										2b. HOUR																													
SHERWOOD										CRUSE										Month 12-24- Day 68 Year 7:10 PM																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years lost birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
MALE										WHITE										10-16-12										56 YRS																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
Maryland										U.S.A.																				BALTIMORE																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR INDUSTRY																													
TOWSON										St. Joseph's Hospital										none																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY, Y.N.T.S?										13e. STREET AND NUMBER																			
Maryland										Baltimore										Parkville										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										3003 Parktowne Road, 34																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																	
First Middle Last										First Middle Last																																																	
Maynard										Cruse										Katherine										Schoen																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (known)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
no										none										Gaudiel Clara E. Esslinger										same																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART I. DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a)										Bacterial pneumonia										Septicemia																																							
4 X										DUE TO, OR AS A CONSEQUENCE OF																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b) Broncho-pneumonia																																																	
										DUE TO, OR AS A CONSEQUENCE OF																																																	
										(c) Congestive heart failure																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																																																											
471X																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																																							
										HOUR A.M. Month Day Year 19 P.M.																																																	
21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)										21f. LOCATION										Street or RFD No City or Town County State																													
22a. I certify that (X) (this hospital) attended the deceased from 12-21-1968, to 12-24-1968, that (X) (we) last saw the deceased alive on 12-24-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										22c. DATE SIGNED																																																	
L. Gaudiel, M.D.										12-24-68																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
L. Gaudiel, M.D.										7620 York Rd., Towson, Md. 21204																																																	
23a. BURIAL, CREMATION, or other disposition										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										12/28/68										Loudon Pk. Cem.										Balto. Md.																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
Leonard J. Ruck Inc. Balto. Md.																				DEC 26 1968										Charles Judge																													

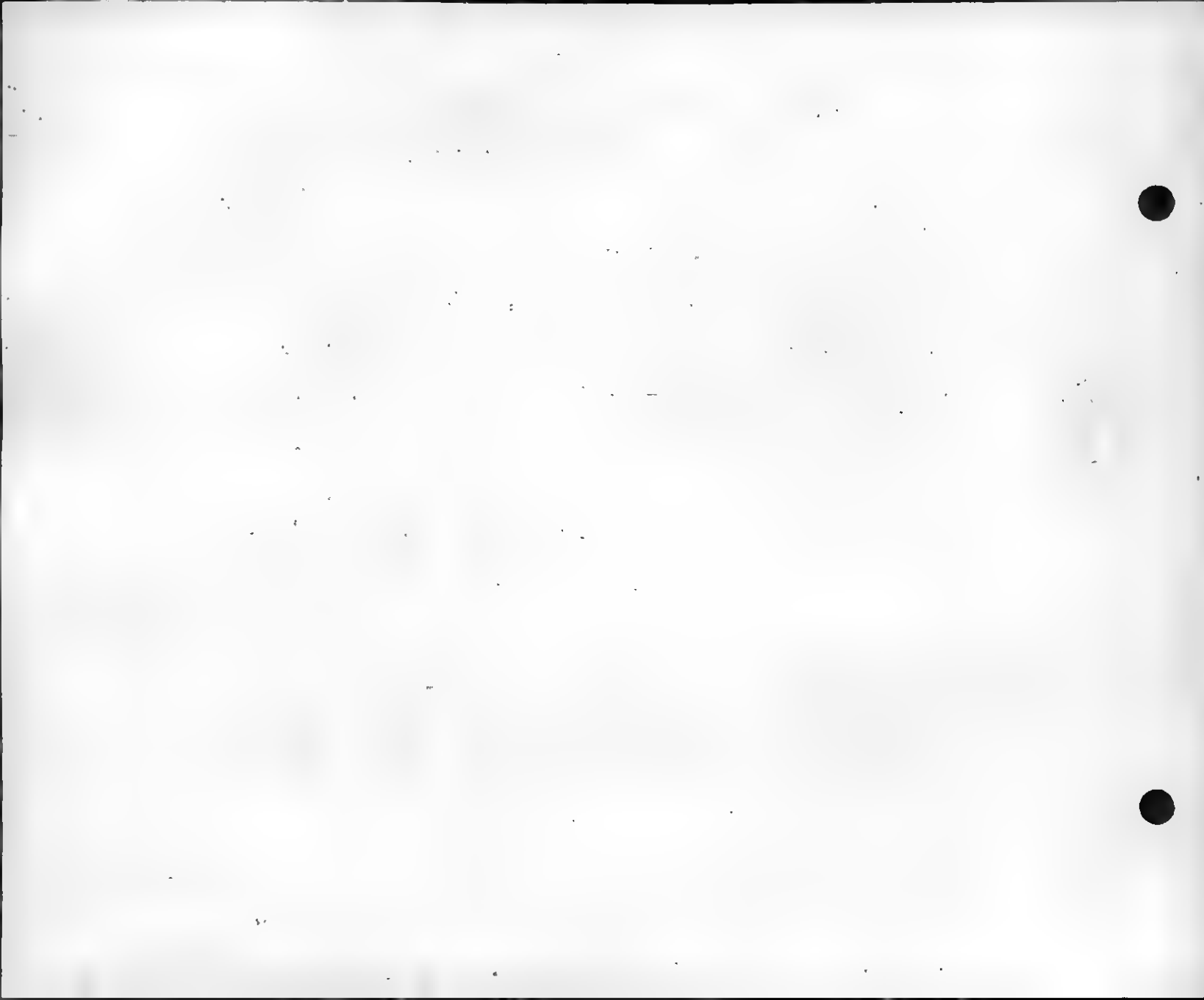
VR A15 45M 68



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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16901												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
Item 7 Film 08 1/2/69 kk						CERTIFICATE OF DEATH			17002			
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
Lucinda Massey Cunabaugh						12/ 10/ 68			11.45 AM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		7. UNDER 1 YEAR			
F		W		2/28/82			88 YRS		MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
England			US						Baltimore Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore			Augsburg Luth Home			Receptionist						
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md			Howard			Ellicott City			NO <input type="checkbox"/>		Route 2	
14. FATHER'S NAME First Middle Last						15. MOTHER'S MAIDEN NAME First Middle Last						
James MASSEY						Cambell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT			Address			
			212-03-0699			Records			A.L.H. 6811 Campfield Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adeno carcinoma of uterus</i> 1829 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Diabetes Mellitus</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arterio Sclerotic Heart Disease</i> 174X PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Generalized arterio Sclerosis</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
										3 yrs.		
										10 yrs.		
										5 yrs.		
MEDICAL CERTIFICATION												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. no. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov. 1961</i> to <i>dec. 1968</i> , that (I) <i>(was)</i> lost saw the deceased alive on <i>12/5</i> 19 <i>68</i> , and that in (my) <i>(was)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(was)</i> <i>(did)</i> view the body after death.												
22b. SIGNATURE <i>Earl L. Chambers M.D.</i>						DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>12/13/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Earl Chambers</i>						22e. ADDRESS <i>100-W. Cold Spring Bay Balto. Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			12/13/68			Loudon Park			Baltimore			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Paul A. Heemann 6067 Harford R.,						DATE DEC 16 1968			<i>J. Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

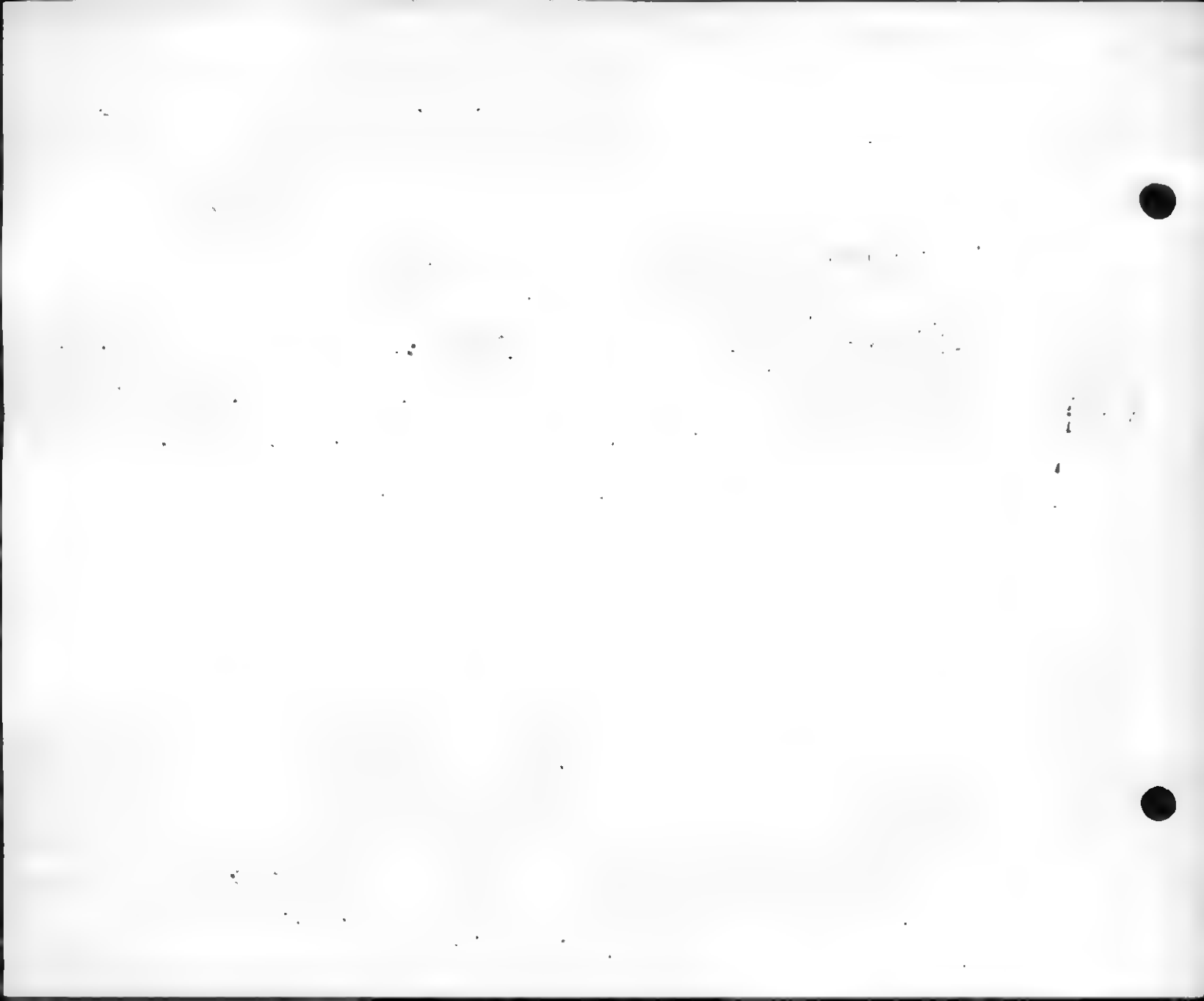
VR A1524
30M REV. 64

16992

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17003

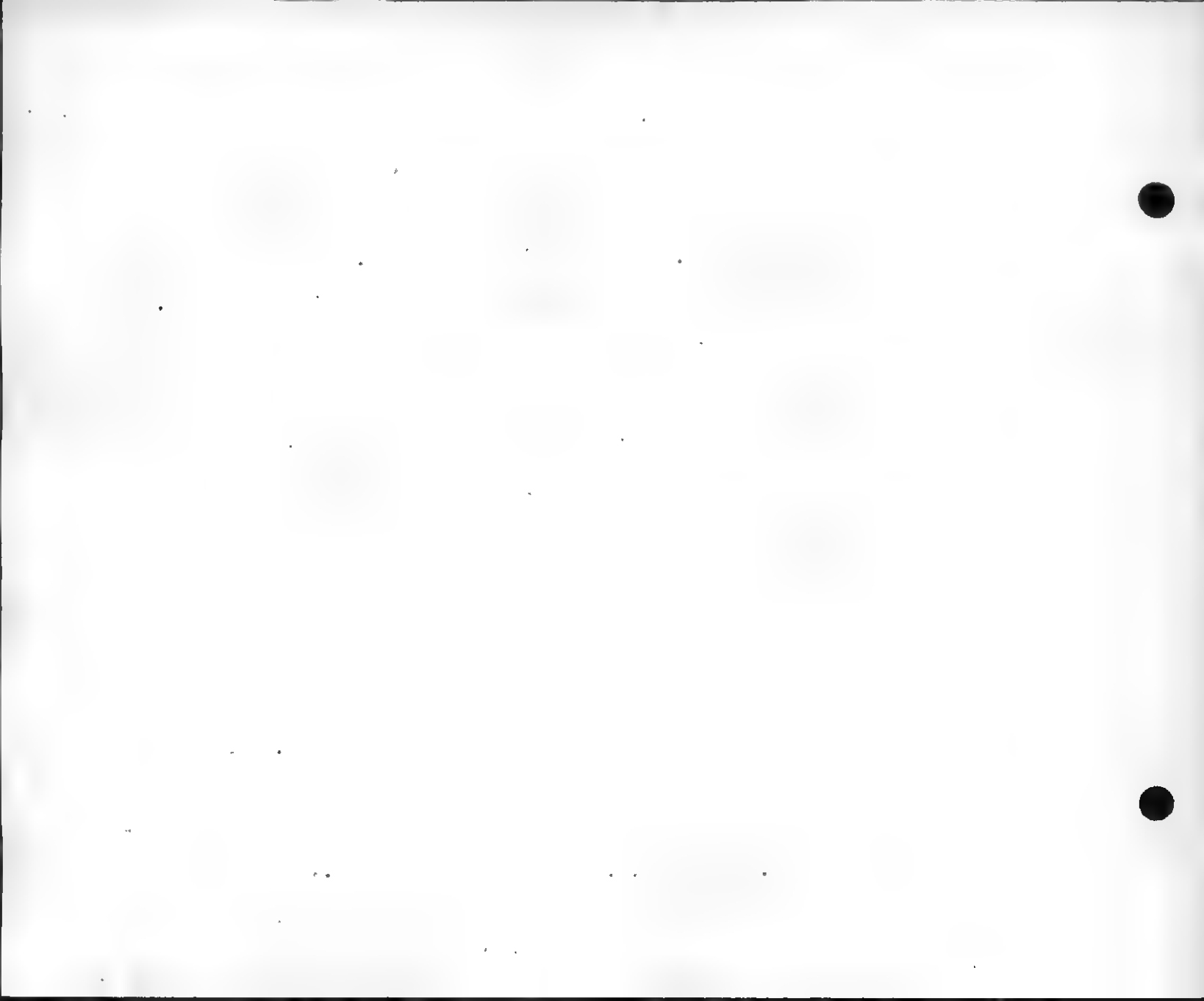
1. DECEASED-NAME (Type or print) First Middle Last LUGI CURRO			2a. DATE OF DEATH Month Day Year DEC 1 1968		2b. HOUR 10:40 AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 1/7/89		6. AGE (In years last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) SICILY	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore County, Md.		
10. CITY OR TOWN OF DEATH Mount Wilson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SEWER REPAIR MAN	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13b. COUNTY PRINCE GEORGE'S	13c. CITY OR TOWN CHILLUM	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5607 BURGESS DRIVE
14. FATHER'S NAME First Middle Last PAUL L. CURRO		15. MOTHER'S MAIDEN NAME First Middle Last ANTONINA GRASSO CURRO			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO 578-48-3697		17. INFORMANT Address Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT WITH RT. HEMIPLEGIA DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS, GENERALIZED DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 mo. 10 YRS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) MILITARY TUBERCULOSIS					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from JUNE 1968 to DEC 1968, that (I) (we) last saw the deceased alive on DEC 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W. Newcomer				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.				22e. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4 DECEMBER 1968		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN MAUSOLEUM	
24. FUNERAL DIRECTOR RINALDI FUNERAL HOME, WASH., D.C.		23d. LOCATION (City or Town) (County) (State) BLADENSBURG MARYLAND		25a. REC'D BY REGISTRAR DATE DEC 3 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal after death, within 72 hours after death.

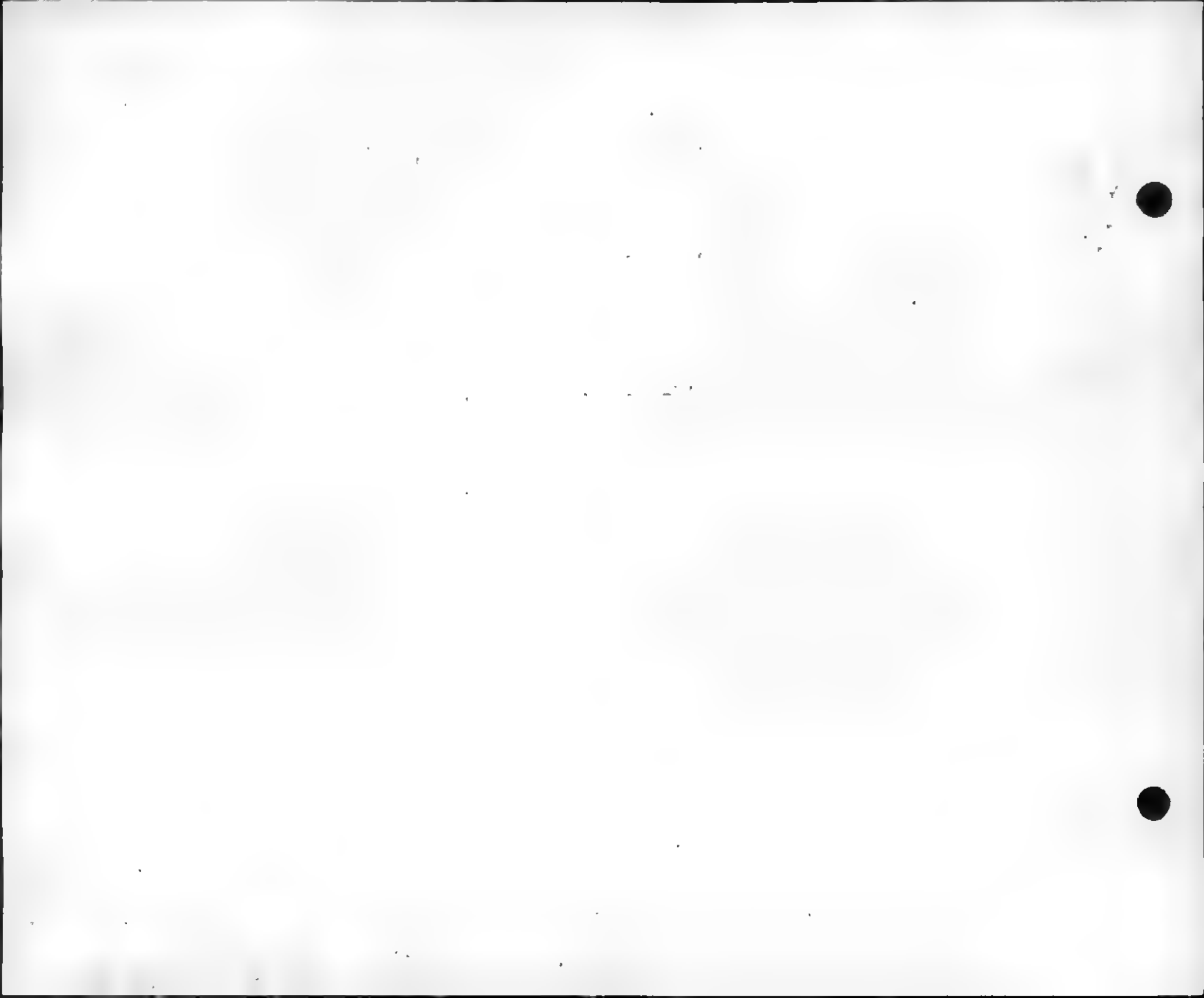
16998										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17004																													
1. DECEASED-NAME (Type or print)										20. DATE OF DEATH										2b. HOUR																													
First Middle Last WILLIAM H. CURTIS JR.										Month Day Year December 12, 1968										3:45 AM																													
3. SEX Male										4. RACE White										5. DATE OF BIRTH April 20, 1915										6. AGE (In years lost birthday) 53 YRS										F UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Baltimore Md																			
10. CITY OR TOWN OF DEATH Towson										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Md. State Fair										12b. KIND OF BUSINESS OR INDUSTRY																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b. COUNTY Baltimore										13c. CITY OR TOWN Cockeysville										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 829 Warren Rd. 21030									
14. FATHER'S NAME First Middle Last William Harrison Curtis Sr.										15. MOTHER'S MAIDEN NAME First Middle Last Rosa Virginia Curtis										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No										16b. SOCIAL SECURITY NO. 217-16-4259										17. INFORMANT Address Mrs. Roseanna Curtis Same as # 13 E									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure with Atrial Fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cirrhosis of the Liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from <u>November 29, 1968</u> , to <u>Dec. 12, 1968</u> , that (I) (we) last saw the deceased alive on <u>December 12, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										22b. SIGNATURE Camilo L. Tomboc										22c. DATE SIGNED 12-12-68																													
22d. PHYSICIAN'S NAME (Type) Camilo L. Tomboc, M.D.										22e. ADDRESS 7620 York Rd., Towson Md. 21204										22f. DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>																													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 12-14-68										23c. NAME OF CEMETERY OR CREMATORY Poplar Grove Cemetery										23d. LOCATION (City or Town) (County) (State) Cockeysville Maryland																			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson Inc.										25a. REC'D BY REGISTRAR 1050 York Road Towson, Md. 21204										25b. REGISTRAR'S SIGNATURE DEC 13 1968 Charles Judge																													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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16994										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17005																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First HELEN										Middle M.										Last DAILEY										December ^{Month} 20 ^{Day} 1968 ^{YRS}										9:55 ^{PM}																			
3 SEX Female										4 RACE White										5 DATE OF BIRTH April 22, 1903										6 AGE (n years lost birthday) 65 YRS										7 UNDER 1 YEAR MONTHS DAYS										8 UNDER 24 HRS HOURS MIN									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? USA										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH Baltimore Md																													
10 CITY OR TOWN OF DEATH Towson										11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) St. Joseph's Hospital										12a. USUAL OCCUPATION (Kind of work done during usual working life, even if retired) Homemaker										12b. KIND OF BUSINESS OR INDUSTRY																													
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland										13b. CITY OR TOWN Baltimore										13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13d. STREET AND NUMBER 1408 Maywood Ave.																													
14 FATHER'S NAME First Clifton										Middle Sykes										Last Sarah										15 MOTHER'S MAIDEN NAME First Lindsey										Middle Lindsey										Last Lindsey									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)										16b. SOCIAL SECURITY NO 215-01-7922A										17 INFORMANT Fred N. Dailey										Address 1408 Maywood Ave. 21204																													
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pulmonary thrombo-embolism 4510 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Thrombophlebitis, left leg DUE TO, OR AS A CONSEQUENCE OF (c)																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 463X																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)										21f. LOCATION Street or R.F.D. No City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 12-16 , 19 68 , to 12-20 , 19 68 , that (I) (we) last saw the deceased alive on 12-20 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																																																											
22b. SIGNATURE J. Cilliani										DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>										22c. DATE SIGNED Dec. 20, 1968																																							
22d. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D.										22e. ADDRESS 7620 York Road, Towson 4, Maryland																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial										23b. DATE 12/23/68										23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley										23d. LOCATION (City or Town) (County) (State) Balto. Md.																													
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home										ADDRESS 6500 York Rd. #21212										25a. REC'D BY REGISTRAR DEC 27 1968										25b. REGISTRAR'S SIGNATURE Charles Judge																													



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

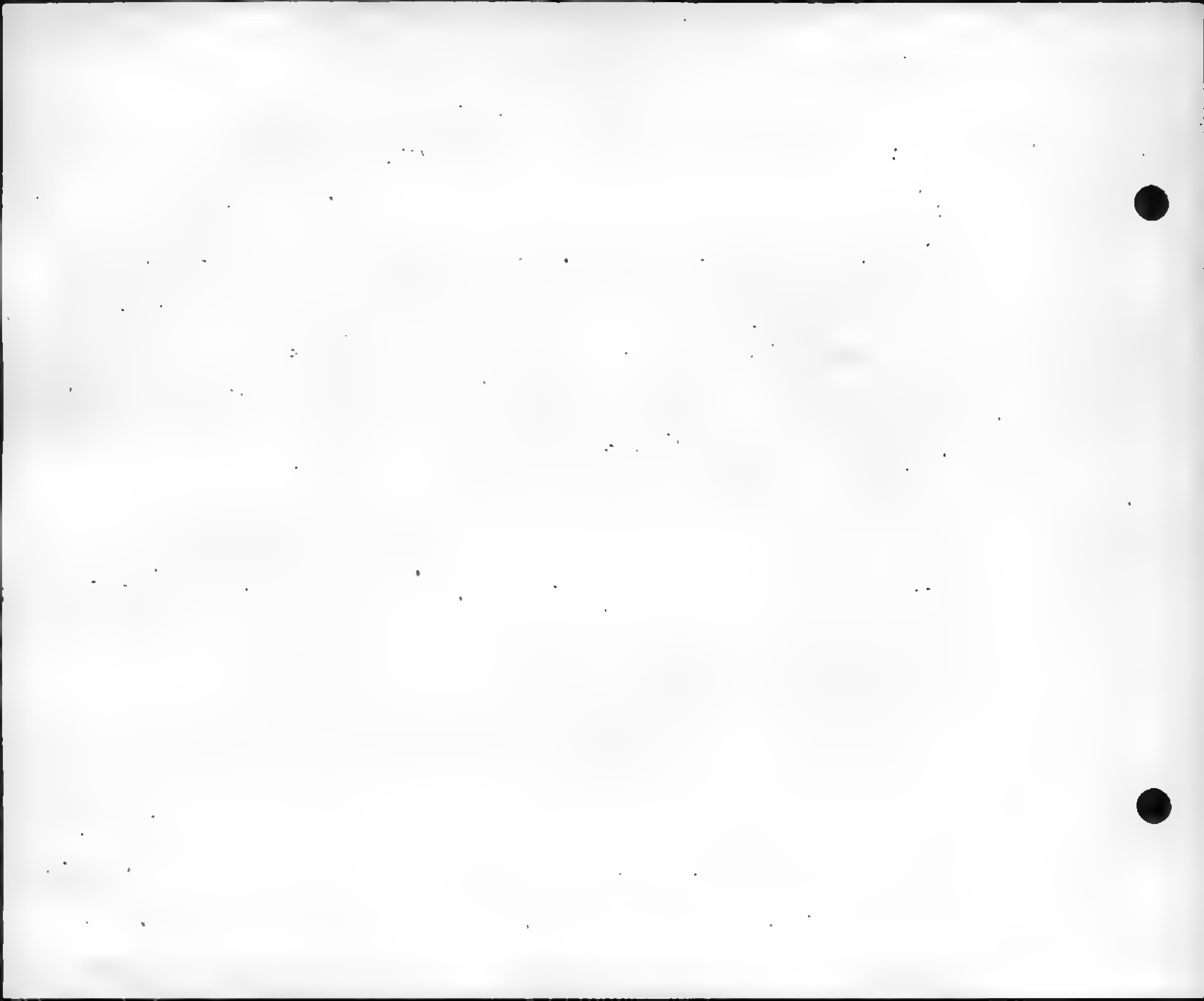
17006

16905

1. DECEASED NAME (Type or print) First Middle Last John DANE			2a. DATE OF DEATH Month Dec Day 21 Year 1968			2b. HOUR 10:15 PM	
3. SEX M		4. RACE Cauc		5. DATE OF BIRTH 3/27/1886		6. AGE (In years last birthday) 82 YRS.	
7a. BIRTHPLACE (State or foreign country) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Catoonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sharyra-ba Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Power tools	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Balt		13c. CITY OR TOWN Catoonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 6007 Johnnycake Rd.							
14. FATHER'S NAME First Middle Last Frederick T DANE			15. MOTHER'S MAIDEN NAME First Middle Last Ida Reynolds				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 215-10-1013		17. INFORMANT Address Ruth Harris 6007 Johnnycake Rd Balt.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: not related to Influenza IMMEDIATE CAUSE (a) Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491X DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Parkinsons Disease, Chronic Urinary tract infect, cataracts, Diabetes, ASCID							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from 12 Nov , 19 68 , to 21 Dec , 19 68 , that (1) (we) last saw the deceased alive on 21 Dec , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard R. Stephenson MD				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 21 Dec 1968	
22d. PHYSICIAN'S NAME (Type) Richard R. Stephenson				22e. ADDRESS 1302 Crofton Road Balt. Md 21212			
23a. BURIAL, CREMATION, REMOVAL (Specify) Crem		23b. DATE 12/24/68		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City or Town) (County) (State) Woodlawn Balt Co Md	
24. FUNERAL DIRECTOR Wm. Cook-Brooks West Inc Balt. Md.				25a. REC'D BY REGISTRAR DEC 30 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16996

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17007

1 DECEASED NAME (Type or print) Matilda		First MATILDA Middle		Last DANIELS		2a. DATE OF DEATH Month 12 Day 10 Year 68		2b. HOUR 11:45 M	
3 SEX F		4 RACE W		5. DATE OF BIRTH 1/8/95		6 AGE (In years last birthday) 73 YRS.		IF LONGER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS M.N.	
7a. BIRTHPLACE (State or foreign country) Poland		7b. CIT ZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.			
10 CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit M.H.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Shirt Mfg.			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET AND NUMBER 4215 W. 1/2 Birch Ave.	
14. FATHER'S NAME First Middle Last Martin		15. MOTHER'S MAIDEN NAME First Middle Last Maryanna Lublenska							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO 216-14-7575		17 INFORMANT Address Mrs. Cordelia Woody, 5200 Talbot Pl. (27)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma of the head of the pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Jaundice DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1572 HYDRO NECH.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION 11/14/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Explor. Laparotomy		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11/22 , 19 68 , to 12/10 , 19 68 , that (I) (we) last saw the deceased alive on 12/10 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. Kozan, Jr. M.D.		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 12/11/68			
22d. PHYSICIAN'S NAME (Type) E. KASAPITIS, M.D.		22e. ADDRESS 1801 Frederick Road Baltimore		21228					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/14/68		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE		ADDRESS		25a. REC'D BY REGISTRAR DEC 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16992

CERTIFICATE OF DEATH

17008

1 DECEASED NAME (Type or print) Baby		First Middle Last		2a DATE OF DEATH Month Day Year DECEMBER 27, 1968		2b HOUR P 11:30 PM	
3 SEX Male		4 RACE WHITE		5 DATE OF BIRTH DECEMBER 27, 1968		6 AGE (In years last birthday) YRS MONTHS DAYS 2 59	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE	
10 CITY OR TOWN OF DEATH TOWSON 4		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b COUNTY BALTIMORE		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 9416 Dana Vista Road	
14 FATHER'S NAME First Middle Last CARL DANNENFELSER		15 MOTHER'S MAIDEN NAME First Middle Last BARBARA KALBSKEPP					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT Address Carl E Dannenfels 9416 Dana Vista			
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) IMMATURITY 77x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Immaturity DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 116x							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that (X) (this hospital) attended the deceased from DEC. 27, 1968 to DEC. 27, 1968 , that (X) (we) last saw the deceased alive on Dec. 27, 1968 , and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did not) view the body after death.							
22b SIGNATURE Ayestarain		DEGREE ATTENDING PHYS <input type="checkbox"/> MED <input type="checkbox"/> STAFF DIRECTOR PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED Dec. 27, 1968			
22d. PHYSICIAN'S NAME (Type) E. Ayestarain, M.D.		22e. ADDRESS 7620 York Road, Towson 4, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 12/30/68		23c NAME OF CEMETERY OR CREMATORY Parkwood Cem.		23d LOCATION (City or Town) (County) (State) Parkville Balto. Co. Md	
24 FUNERAL DIRECTOR Charles Judge		ADDRESS 7401 Belair Rd.		25a RECEIVED BY REGISTRAR DATE JAN 3 1969		25b REGISTRAR'S SIGNATURE Charles Judge	



HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M

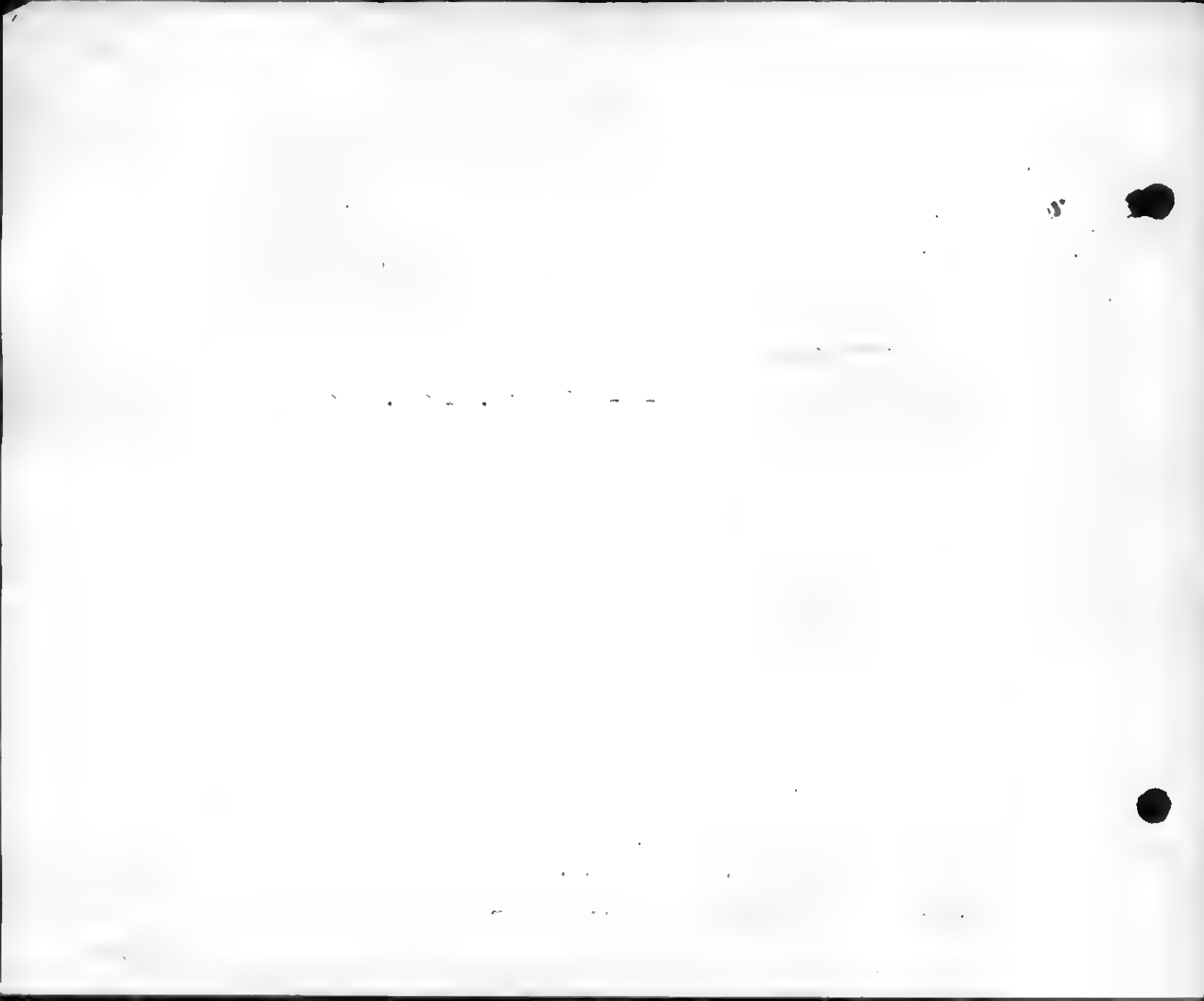
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16998

CERTIFICATE OF DEATH

17009

1. DECEASED-NAME (Type or print) Richard			First Daros			Last Daros			2a. DATE OF DEATH Month 12 Day 26 Year 1968			2b. HOUR 11:55 AM		
3 SEX Male			4. RACE White			5. DATE OF BIRTH October 13, 1913			6. AGE (In years last birthday) 55 YRS			IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) Italy			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore,			Md		
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a. USUAL OCCUPATION (Kind at work done during most of working life, even if retired) Bricklayer			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before address on) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 301 Joplin St.		
14. FATHER'S NAME First Anthony Middle DaRos			Last DaRos			15. MOTHER'S MAIDEN NAME First Rose Middle Casagrande			Last Casagrande					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) Yes			16b. SOCIAL SECURITY NO 081-09-8973			17. INFORMANT Mrs. Rita C. Daros			Address Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CHRONIC MYELOGENOUS LEUKEMIA 2051 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 204														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (A) (this hospital) attended the deceased from 12/12/1968 , to 12/26/1968 , that NO (we) saw the deceased alive on 12/26/1968 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, NO (we) (did) (did not) view the body after death.														
22b. SIGNATURE Samuel C. H. Lee, M.D.			22c. DATE SIGNED 12/26/68			22d. PHYSICIAN'S NAME (Type) Samuel C. H. Lee, M.D.			22e. ADDRESS 7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, or other disposal (Specify) Burial			23b. DATE 12/28/68			23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore Maryland					
24. FUNERAL DIRECTOR Leonard J. Puckler			ADDRESS 5305 Hartford Rd.			25a. REC'D BY REGISTRAR DEC 27 1968			25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Davis 16993

CERTIFICATE OF DEATH

17010

1 DECEASED-NAME (Type or print) <i>Frank</i>			First <i>L</i> Middle <i>Davis</i> Last			2a. DATE OF DEATH Month <i>Dec</i> Day <i>16</i> Year <i>68</i>			2b. HOUR <i>12:45</i> M					
3 SEX <i>male</i>			4. RACE <i>White</i>			5 DATE OF BIRTH <i>August 14, 1909</i> <i>Dec 16, 1908</i>			6 AGE (In years lost birthday) <i>34</i> YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a BIRTHPLACE (State or foreign country) <i>Munnsville N.I.</i>			7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <i>Baltimore</i> Md.					
10 CITY OR TOWN OF DEATH <i>Cattonsville</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Summit Nursing Home</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Bacteriologist Ret.</i>			12b KIND OF BUSINESS OR INDUSTRY <i>Dairy Eng.</i>					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>			13b COUNTY <i>Balto.</i>			13c CITY OR TOWN <i>Pikesville</i>			13d ASIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER <i>4202 Lowell Dr. 21208</i>		
14 FATHER'S NAME First <i>Thomas Davis</i> Middle Last						15. MOTHER'S MA DEN NAME First <i>Melora Unknown</i> Middle Last								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i> (If yes give war or dates of service)						16b SOCIAL SECURITY NO <i>216-C3-9426</i>			17 INFORMANT Address <i>Mrs. Sarah L. Davis 4202 Lowell Dr. 21208</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>471X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Influenza</i> DUE TO, OR AS A CONSEQUENCE OF <i>Arteriosclerosis, cardiac vascular disease; Complete Heart Block</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>480X</i>														
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i> P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <i>6/15</i> , 19 <i>67</i> to <i>12/16</i> , 19 <i>68</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>12/15</i> , 19 <i>68</i> , and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(we)</i> <i>(did)</i> (did not) view the body after death.														
22b. SIGNATURE <i>Edmund Hamm</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <i>12/16/68</i>								
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS								
23a. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>12/18/68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cem.</i>			23d. LOCATION (City or Town) (County) (State) <i>Pikesville Balto. Co. Md.</i>					
24. FUNERAL DIRECTOR <i>Loring Byers</i> ADDRESS <i>8728 Liberty Rd. Randallstown, Md.</i>						25a. RECD BY REGISTRAR <i>DEC 19 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

MEDICAL CERTIFICATION

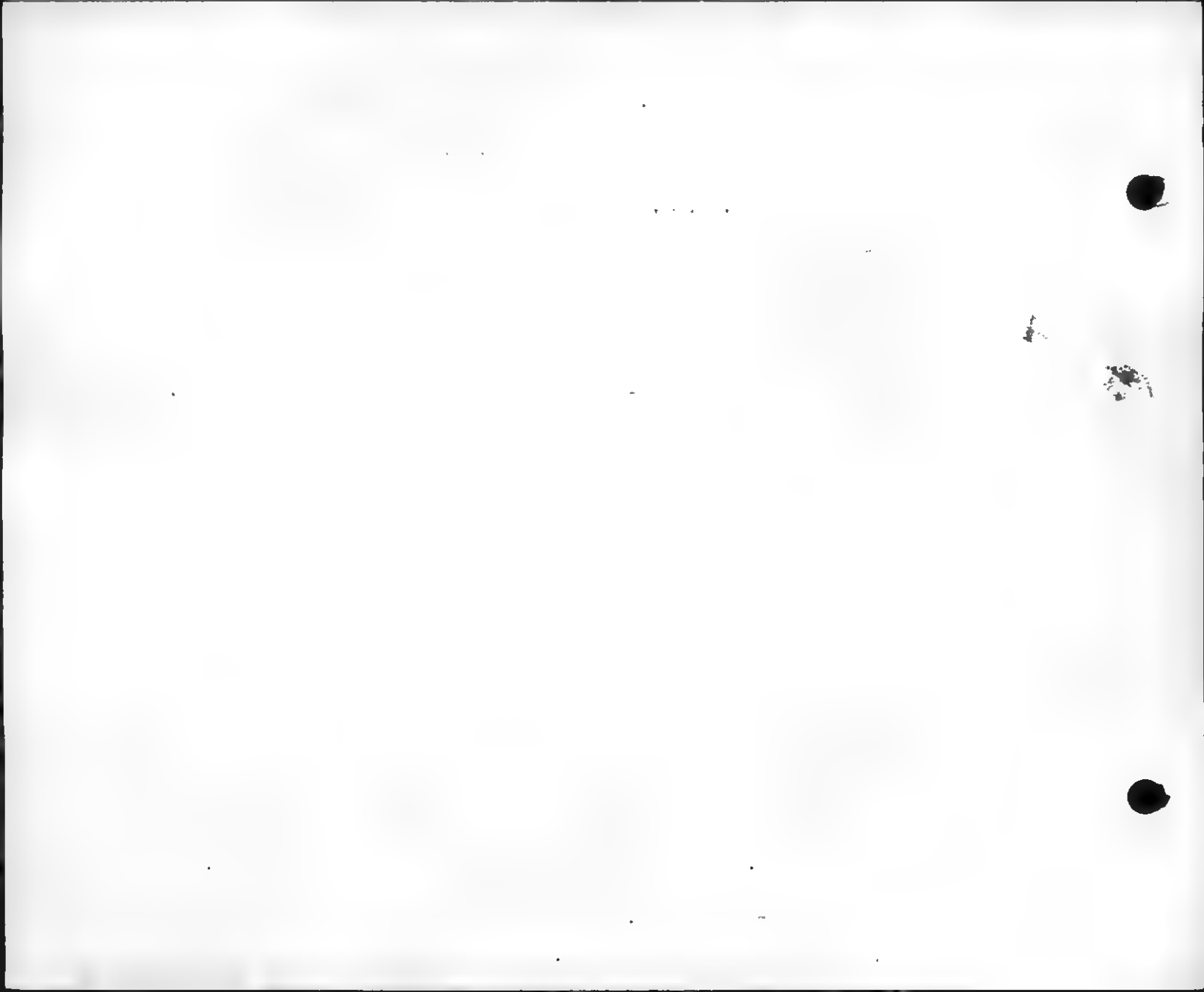


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VR A15 (4)
30M REV. 1-68

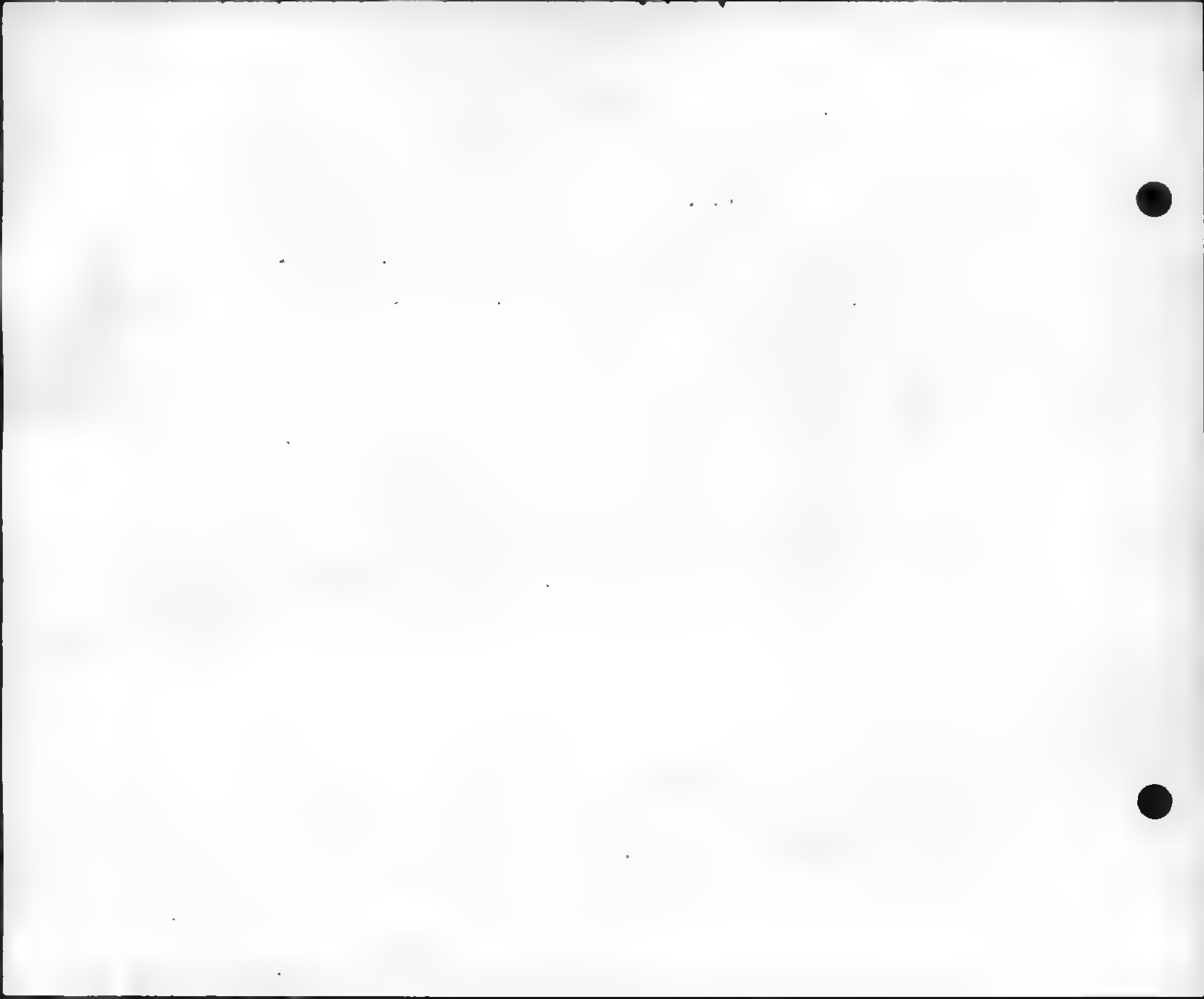
17090										17011									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Anna		Middle M.		Last Dembowski			2a. DATE OF DEATH December 12 Day 1968				2b. HOUR M					
3 SEX F			4. RACE W			5. DATE OF BIRTH 10-10-1894				6. AGE (In years lost birthday) 74 YRS.		7. UNDER YEAR MONTHS		8. UNDER 24 HRS DAYS		9. UNDER 24 HRS HOURS		10. UNDER 24 HRS MIN	
7a. BIRTHPLACE (State or foreign country) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.										
10. CITY OR TOWN OF DEATH Arbutus			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8 Colony Hill Court 27			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Arbutus			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 8 Colony Hill Court 21227								
14. FATHER'S NAME First Lawrence			Middle Handzlik			Last (Unknown)			15. MOTHER'S MAIDEN NAME First (Unknown)			Middle (Unknown)			Last (Unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO (If yes give war or dates of service) --			17. INFORMANT Address Robert Hegan, 8 Colony Hill Rd. Arbutus 27													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis, acute</u>																<u>minutes</u>			
4129 DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) <u>Arteriosclerotic cardiovascular disease</u>																			
stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u>																			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic cardiovascular disease</u>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
4129 <u>Diabetes mellitus</u>																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No			City or Town			County			State				
22a. I certify that (I) (this hospital) attended the deceased from <u>12/4</u> , 19 <u>68</u> , to <u>12/12</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/10</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <u>Herbert J. Levickas, M.D.</u>			22c. ADDRESS 5404 East Drive, Balto. 21227			22d. DATE SIGNED 12/12/68			22e. ADDRESS 5404 East Drive, Balto. 21227			22f. DATE SIGNED 12/12/68			22g. ADDRESS 5404 East Drive, Balto. 21227				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12-16-68			23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery			23d. LOCATION (City or Town) Sharpsburg, Pennsylvania			23e. LOCATION (County) Sharpsburg, Pennsylvania			23f. LOCATION (State) Sharpsburg, Pennsylvania				
24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. Balto			24b. ADDRESS 21229			25a. REC'D BY REGISTRAR DATE DEC 16 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			25c. ADDRESS 5404 East Drive, Balto. 21227			25d. DATE SIGNED 12/12/68				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last WILLIAM JOSEPH DEMPSEY			2a DATE OF DEATH Month Day Year 12 5 68		2b HOUR 11:15 PM	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 12/7/91		6 AGE (In years lost birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE		Md.	
10 CITY OR TOWN OF DEATH FORT HOWARD		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL, FT HOWARD, MD.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CLERK		12b. KIND OF BUSINESS OR INDUSTRY OIL CO			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 15 E. Center Street	
14 FATHER'S NAME First Middle Last WILLIAM B. DEMPSEY			15 MOTHER'S MAIDEN NAME First Middle Last MARY L. KING						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES		16b. SOCIAL SECURITY NO. 212 12 55 16		17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PHEOCHROMOCYTOMA, BILATERAL, ADRENALS WITH HEMORRHAGE									
255.2 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 224X (b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ARTERIOSCLEROTIC HEART DISEASE, OLD. PULMONARY EMPHYSEMA, BILATERAL, OLD									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that (1) (this hospital) attended the deceased from 10/29/68, 19 to 12/5/68, 19, that (1) (we) last saw the deceased alive on 12/5/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Erhard J. Bunyor, M.D.						22c DATE SIGNED 12/6/68			
22d. PHYSICIAN'S NAME (Type) ERHARD J. BUNYOR, M. D.						22e ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12-9-68		23c NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEMETERY		23d LOCATION (City or Town) BALTIMORE, MD.		(County) (State)	
24 FUNERAL DIRECTOR		ADDRESS W.M. COOK BROOKS INC.		25a DEC BY REG STRA DEC 9 1968		25b REGISTRAR'S SIGNATURE Charles Judge			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-105. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

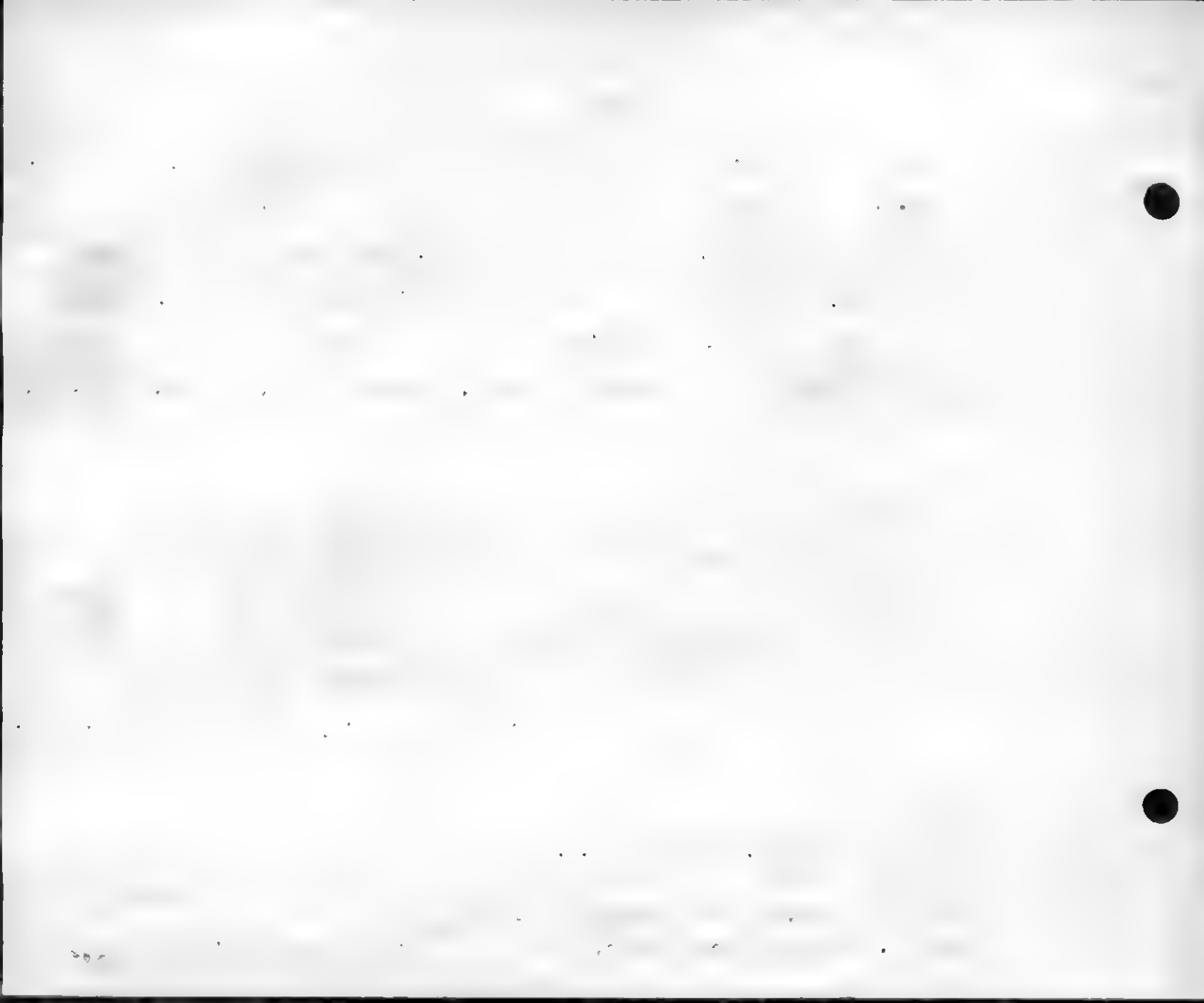
FOR STATE HEALTH DEPT.

17012

STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17013

1 DECEASED NAME (Type or Print) First Middle Last JACK BRYANT DENNING			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year 12-25 1968		2b HOUR M
3 SEX Male	4 RACE White	5 DATE OF BIRTH Oct. 14, 1931	6 AGE (In years last birthday) 37 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) M.C.		7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE
10 CITY OR TOWN OF DEATH White Marsh		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rte. 40 east of Ebenezer Rd.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Steel Worker	12b KIND OF BUSINESS OR INDUSTRY Steel Bethlehem
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Harford	13c. CITY OR TOWN Joppatown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 826 Bradley Rd.
14 FATHER'S NAME First Middle Last Joel -- Denning			15. MOTHER'S MAIDEN NAME First Middle Last Vivian -- Keene		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b SOCIAL SECURITY NO (If yes give year or dates of service) Korean 257-44-3743		17. INFORMANT ADDRESS John F. Denning, Rt. 16, Box 513, Balto. Md. 21220	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 7:00 P.M. 12-25 19 68		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Driver in auto-auto collision	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) highway		21f LOCATION Street or R.F.D. No City or Town County State Rte. #40 1/2 ml. E. of Ebenezer Rd. White Marsh Balt. Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Charles S. Springate</i>		EXAMINER'S NAME (Type) Charles S. Springate, M.D.		22b. DATE SIGNED December 26, 1968	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Dec. 28, 1968	23c NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cemetery		23d LOCATION (City or Town) (County) (State) Joppa Harford Md
24 FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.			25a RECEIVED BY REGISTRAR DEC 30 1968		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

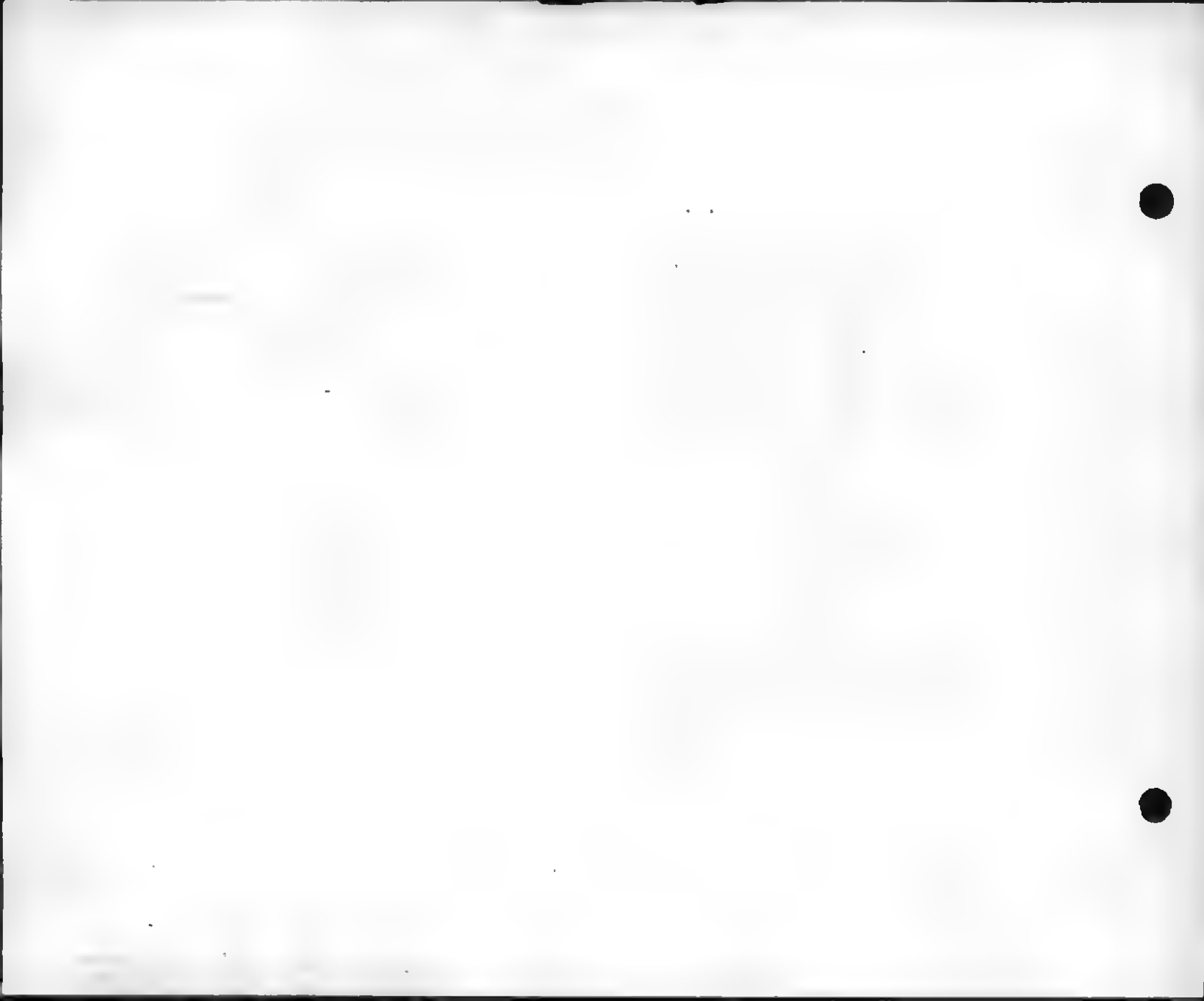
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17093

CERTIFICATE OF DEATH

17014

1 DECEASED NAME (Type or print) First Middle Last Carl William DeTar			2a. DATE OF DEATH Month Day Year December 22 68			2b. HOUR P 9.30M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH 11-5-17		6 AGE (In years last birthday) 51 YRS.	
7a BIRTHPLACE (State or foreign country) Kan.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md	
10 CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None		12b KIND OF BUSINESS OR INDUSTRY None	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Parkville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET AND NUMBER 9019 Charles Ave.,		13f CITY AND STATE Baltimore, Md.		13g ZIP CODE 21236			
14 FATHER'S NAME First Middle Last William H. DeTar			15 MOTHER'S MAIDEN NAME First Middle Last Mattie Elliott				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (p.p. or unknown) (If yes give year or dates of service) No			16b SOCIAL SECURITY NO 513-25-2212		17 INFORMANT Doris ar. DeTar-977, Charles Ave.-2122		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma 571.0 DUE TO, OR AS A CONSEQUENCE OF (b) Laennec Cirrhosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 581.1							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR AM Month Day Year PM 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12-20-1968 to 12-22-1968, that (I) (we) lost saw the deceased alive on 12-22-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Lilia C. Baldonado				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 12-22-68	
22d. PHYSICIAN'S NAME (Type) Lilia C. Baldonado M.D.				22e ADDRESS 7620 York Rd., Towson, Md. 21204			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 12-22-68		23c NAME OF CEMETERY OR CREMATORY C. M. Brown Memorial C.		23d LOCATION (City or Town) (County) (State) Baltimore, Md.	
24 FUNERAL DIRECTOR John C. Miller Inc. - 415 Polair St. - 21206				25a. REC'D BY REGISTRAR DEC 27 1968		25b REGISTRAR'S SIGNATURE Charles Judge	

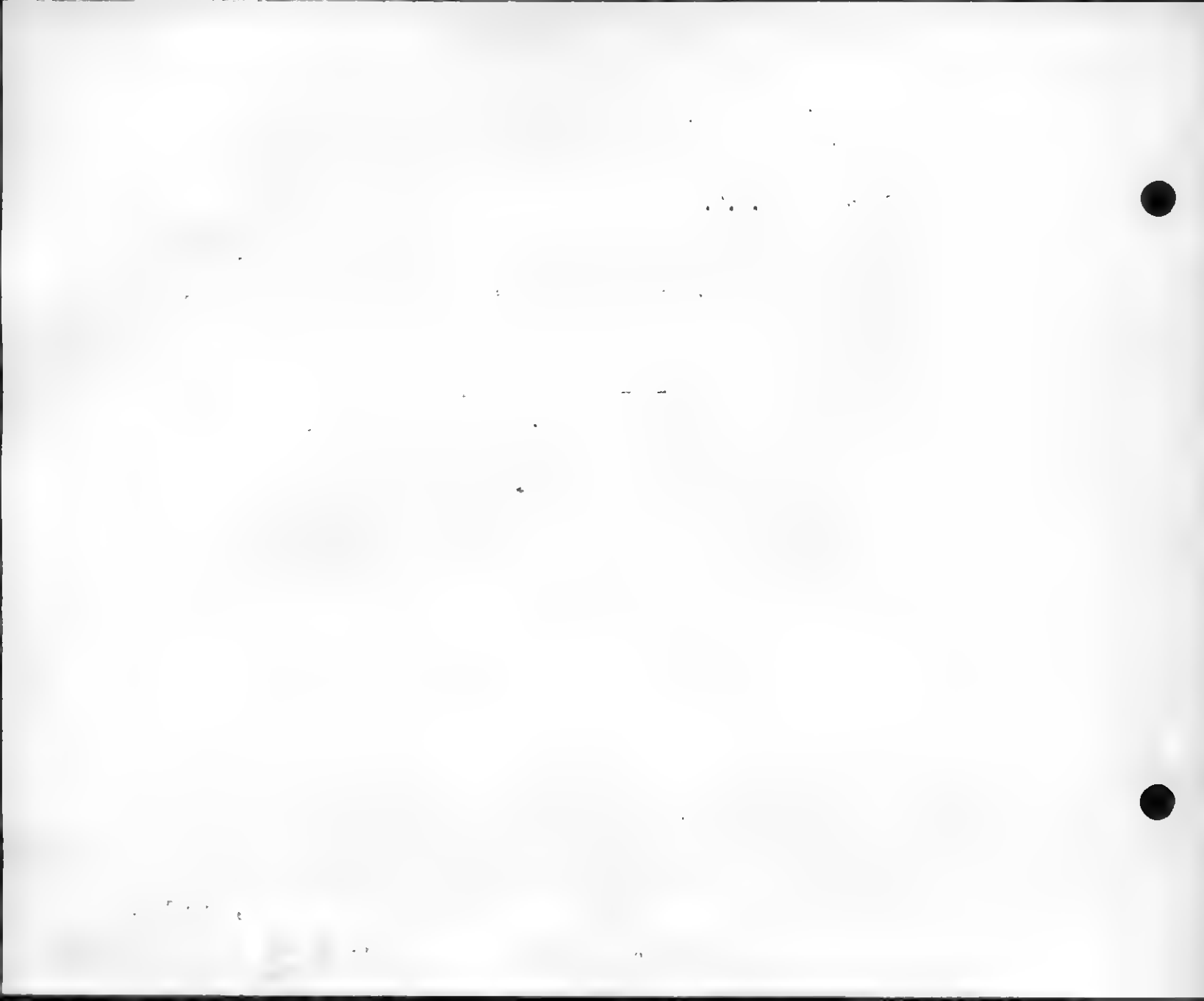


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print) IGNATIUS ALOYSIUS DEWEY						2a DATE KNOWN OF EST DEATH MATED Dec 8 1968		2b HOUR 7:30 AM			
3 SEX MALE		4 RACE White		5 DATE OF BIRTH 17 Feb 1911		6 AGE (in years last birthday) 57 YRS		7 UNDER YEAR MONTHS 0 DAYS 0		8 UNDER 24 HRS HOURS 0 MIN 0	
7a BIRTHPLACE (State or foreign country) Maryland			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Baltimore		
10 CITY OR TOWN OF DEATH Parkville				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3014 Taylor Ave				12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) Assemblyman Fisher		12b KIND OF BUSINESS OR INDUSTRY Body Co	
13a USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland				13b COUNTY Baltimore		13c CITY OR TOWN Parkville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 3014 Taylor Ave	
14 FATHER'S NAME First John Middle A Last Dewey				15. MOTHER'S MAIDEN NAME First Susan Middle Malchitsky Last Malchitsky							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b SOC. A. SECURITY NO 169-18-4434		17 INFORMANT Mrs Viola Dewey			ADDRESS Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) atherosclerotic cardiac lesion 4101 DUE TO, OR AS A CONSEQUENCE OF Dissecting Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 4221 (b) Dissecting DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None known.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unk -	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John C. Hyle				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 12-8-68			
EXAMINER'S NAME (Type) JOHN C. HYLE				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town or county) 7527 Olden Rd Baltimore			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 12/12/68		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR Leonard J Ruck Inc				ADDRESS Baltimore, Maryland				25a. REC'D BY REGISTRAR DEC 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

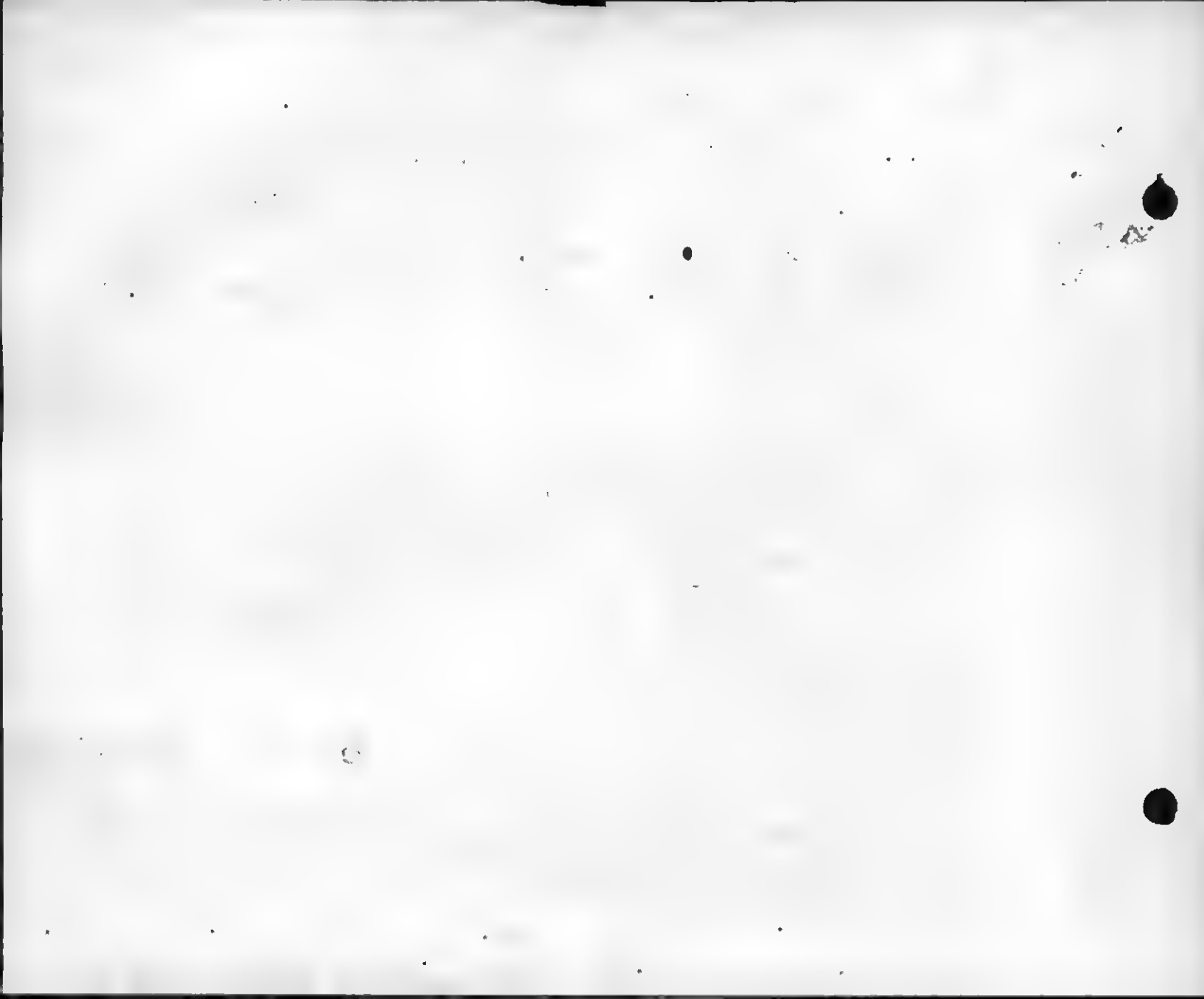
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

Items 5, 6, & 7 File 3-68
1/3/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17016

1 DECEASED-NAME (Type or print) Wenona		First Disney		Last		2c. DATE OF DEATH Dec. Month 24 Day 68 Year		2b. HOUR M	
3 SEX F.M.		4. RACE White		5. DATE OF BIRTH Nov. 14, 1890		6 AGE (In years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Balto. Md.		7b. CTZEN OF WHAT COUNTRY? U A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore County		Md	
10 CITY OR TOWN OF DEATH Randallstown Maryland		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 9202 Turnbull Rd.		12a USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md		13b COUNTY Balto.		13c CITY OR TOWN Randallstown		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER 9202 Turnbull Rd. 21133	
14. FATHER'S NAME First Middle Last		15 MOTHER'S MAIDEN NAME First Middle Last							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Multiple CVA's									
19a DATE OF OPERATION		19b. CONDIT ON FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from June , 19 65 to Dec 24 , 19 68 , that (I) (we) last saw the deceased alive on Apr. 4 , 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John Danell		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 12-24-68			
22d. PHYSICIAN'S NAME (Type) John Darrell		22e. ADDRESS Randallstown, Md.							
23a BURIAL, CREMATION, REMOVAL, (Specify)		23b DATE Dec. 27, 1968		23c NAME OF CEMETERY OR CREMATORY Woodlawn		23d LOCATION (City or Town) (County) (State) Gwyn Oag Ave. Balto Co; Md.			
24. FUNERAL DIRECTOR Loring		Address yers, 8728 Liberty Rd. Randallstown, Md		25a REC'D BY REGISTRAR DEC 30 1968		25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

17006

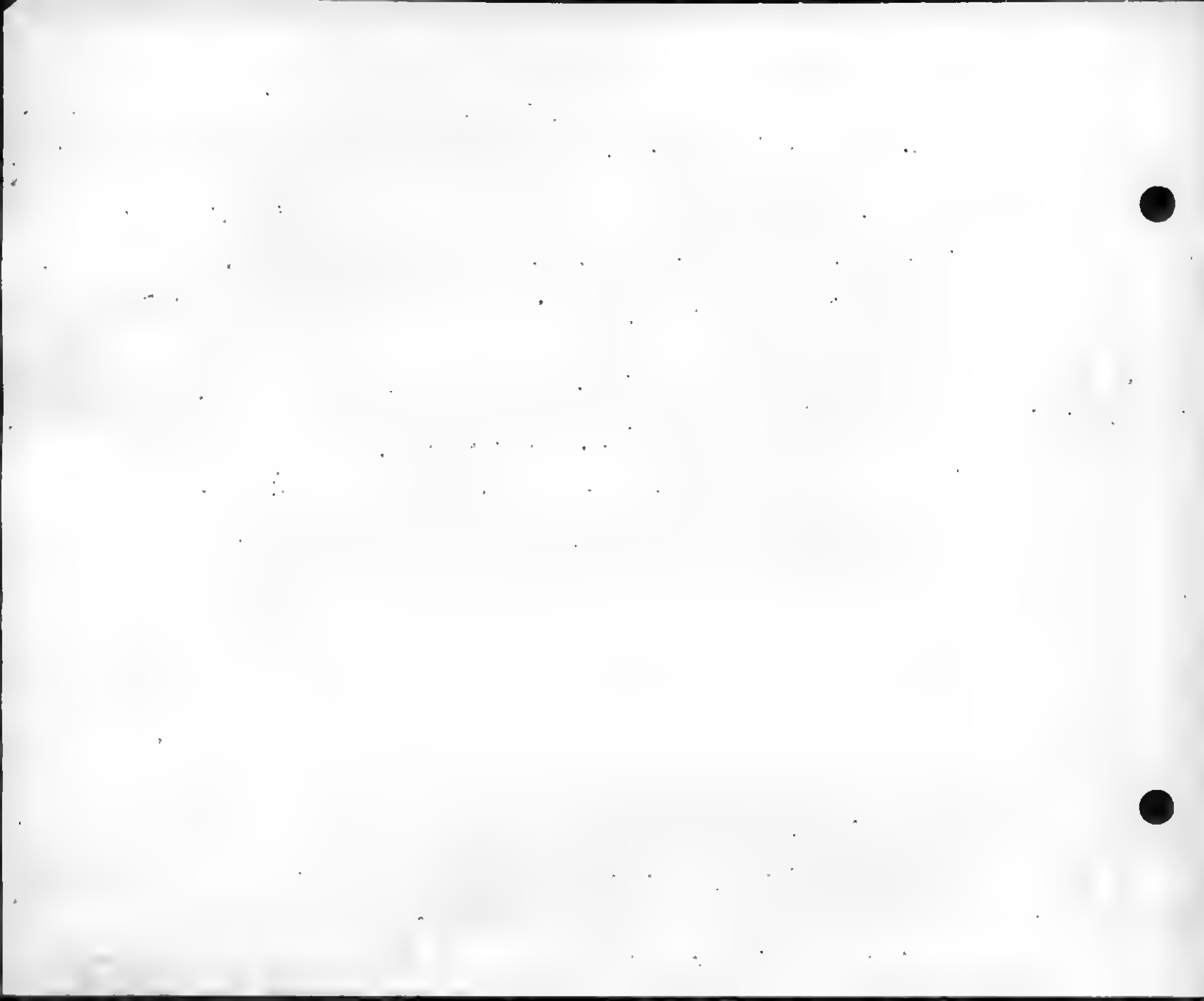
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17017

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR		
GERTRUDE ERNA DITZELL					12 16 1968		1:36 aM		
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER YEAR		
Female	Caucasian		July 12, 1890		78 YRS		MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Germany	USA				Baltimore Md.				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Towson, Md.		Greater Balto. Med. Center		Homemaker					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4410 Valley View Ave.	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
? Jentsch			? Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17 INFORMANT Address					
No		215-50-7209		Raymond C. Ditzell, Jr. 1650 Gleneagle Rd 12					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Complete atrio-ventricular block</u> <u>4120</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertensive arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>475</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/13</u> , 19 <u>68</u> , to <u>12/16</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/16</u> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Charles C. Brown, M.D.</u> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c DATE SIGNED 12/16/68			
22d. PHYSICIAN'S NAME (Type) Charles C. Brown, M. D.				22e. ADDRESS Greater Baltimore Medical Center					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		12/19/1968		Lorraine Park Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR <u>Luella R. Seitz 5209 York Rd. Balto. Md.</u> ADDRESS <u>Seitz Funeral Home 21212</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 18 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATE ON



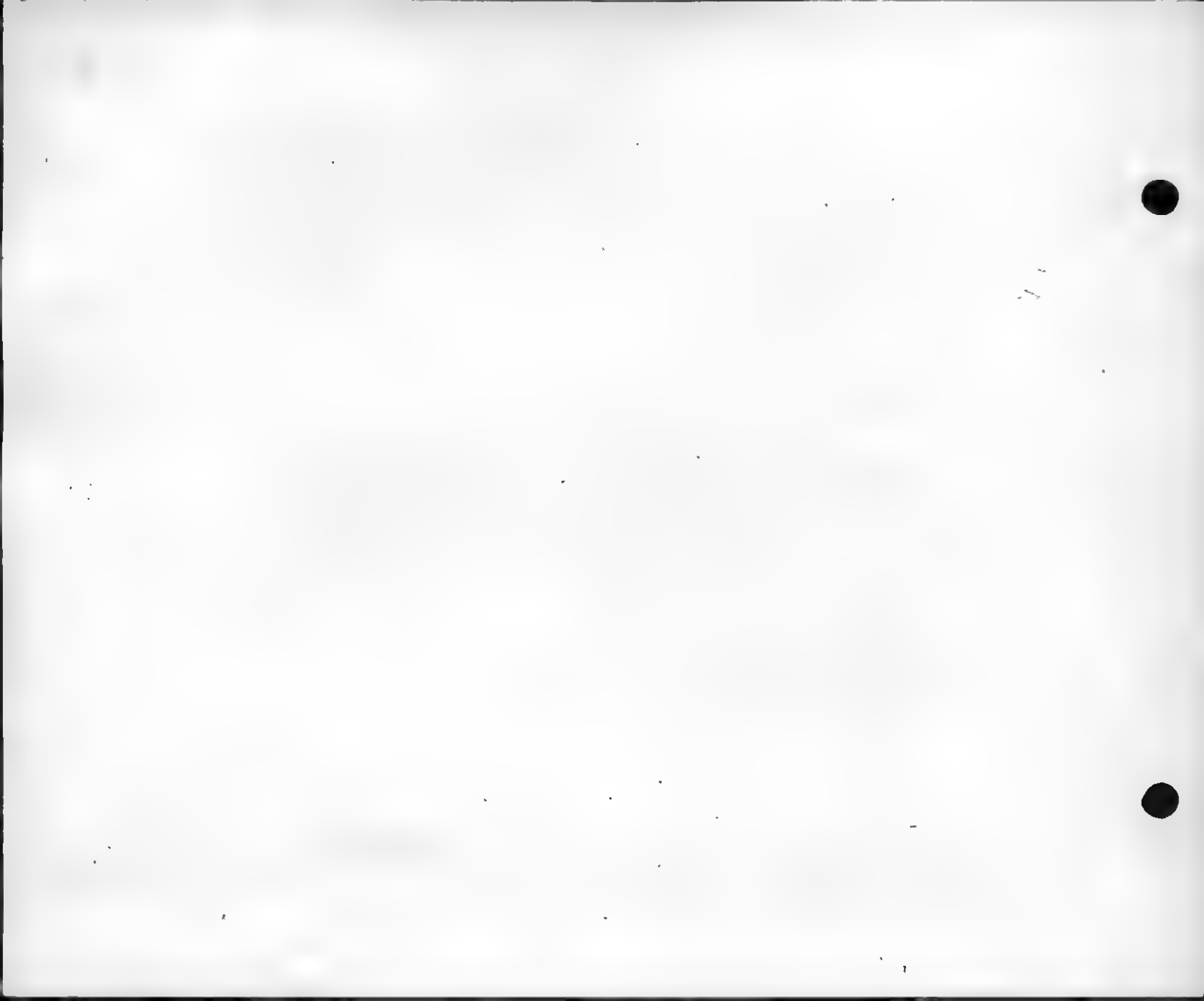
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

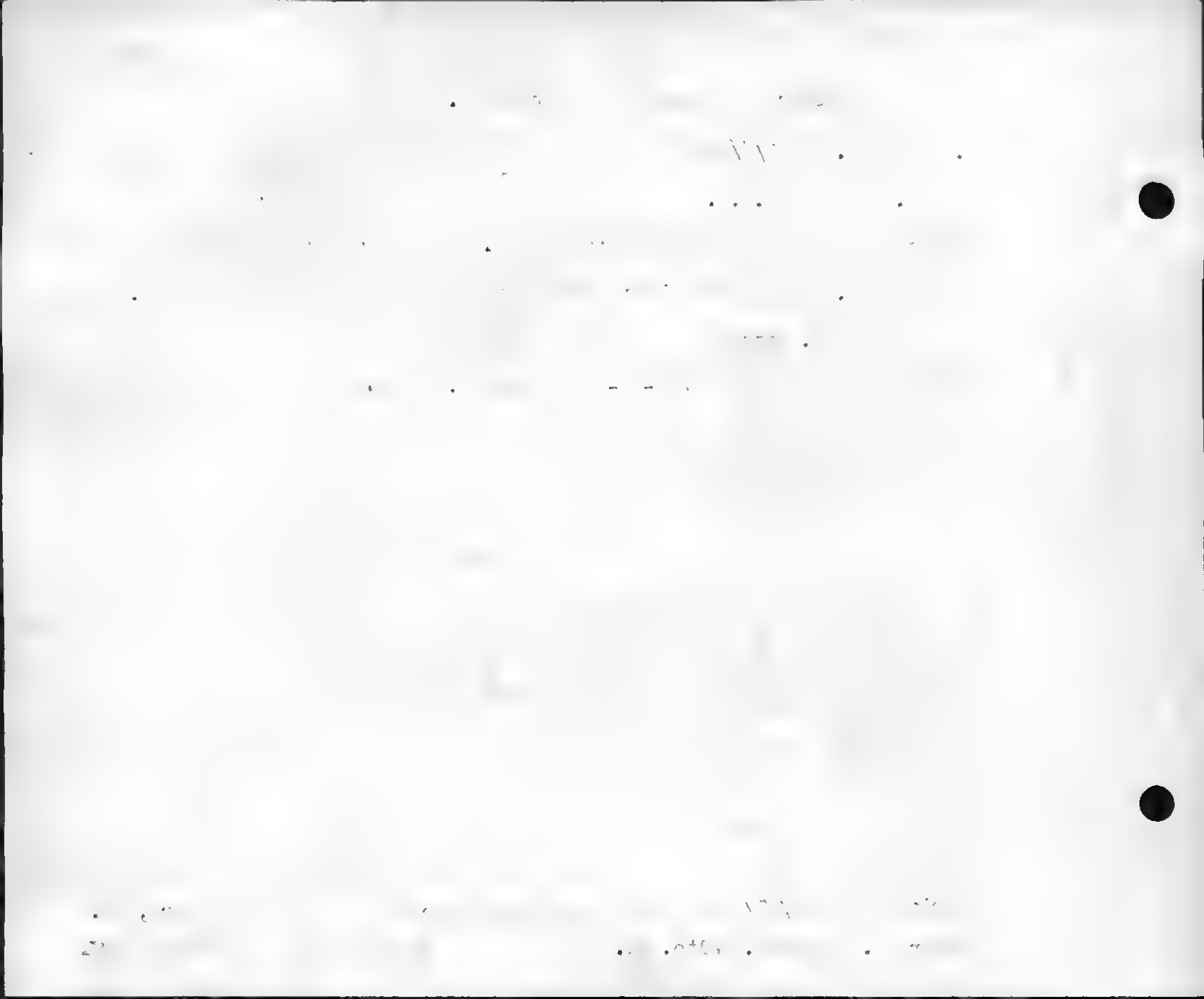
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR							
3 SEX			4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS					
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			2c DATE PRONOUNCED DEAD					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY							
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER				
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT ADDRESS				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF			19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
19c TIME OF INJURY Month, Day, Year			21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town			County		State		
22a I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22b DATE SIGNED			22c NAME OF CEMETERY OR CREMATORY			22d LOCATION (City or Town)			County			State	
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town)			County			State	
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE			25c DATE			25d	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1-2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1000-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

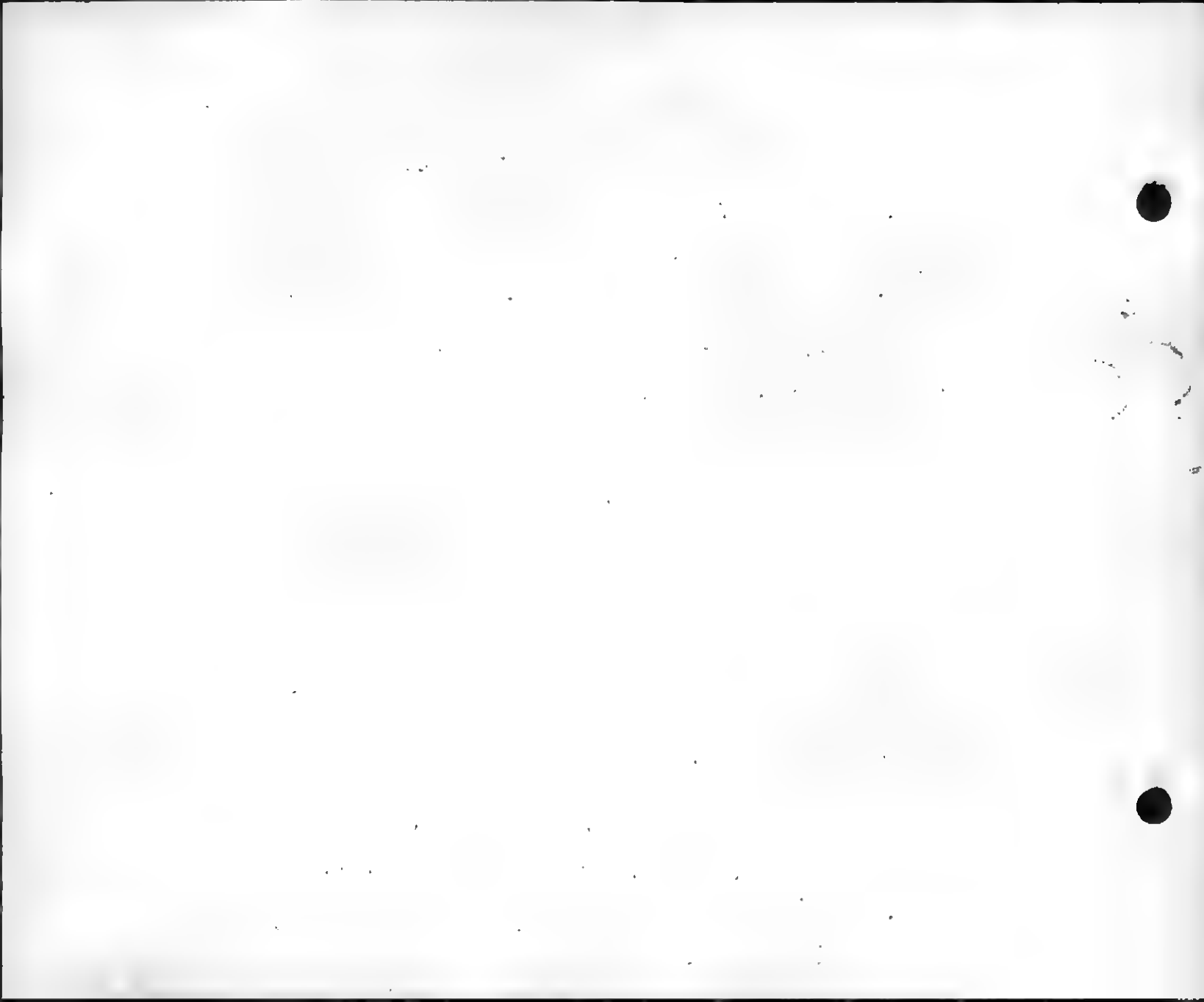
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17020

17020

1. DECEASED NAME (Type or print) First Middle Last ANNE DORSEY			2a. DATE OF DEATH Month Day Year Dec 9 1968			2b. HOUR 10:45				
3. SEX F		4. RACE W		5. DATE OF BIRTH July 26, 1920		6. AGE (In years last birthday) 48 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto. Co. Md				
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 803 Beaverbank Ct.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) At Home			12b. KIND OF BUSINESS OR INDUSTRY *****	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Balto		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 803 Beaverbank Ct.	
14. FATHER'S NAME First Middle Last Frank Grieb			15. MOTHER'S MAIDEN NAME First Middle Last Anna Patzwall							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give year or dates of service) NO			16b. SOCIAL SECURITY NO 217-09-1556		17. INFORMANT Family records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory paralysis</u> 340X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>12 years</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 345X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>63</u> , to <u>Dec 9</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 3</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Richard Fravel</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) C. Richard Fravel M.D.					22e. ADDRESS Sun Life Buldg.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/13/68		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCATION (City or Town) (County) (State) Balto. Co. Md.				
24. FUNERAL DIRECTOR ADDRESS C.F. EVANS & SON 8802 Harford road					25a. REC'D. BY REGISTRAR DATE DEC 16 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

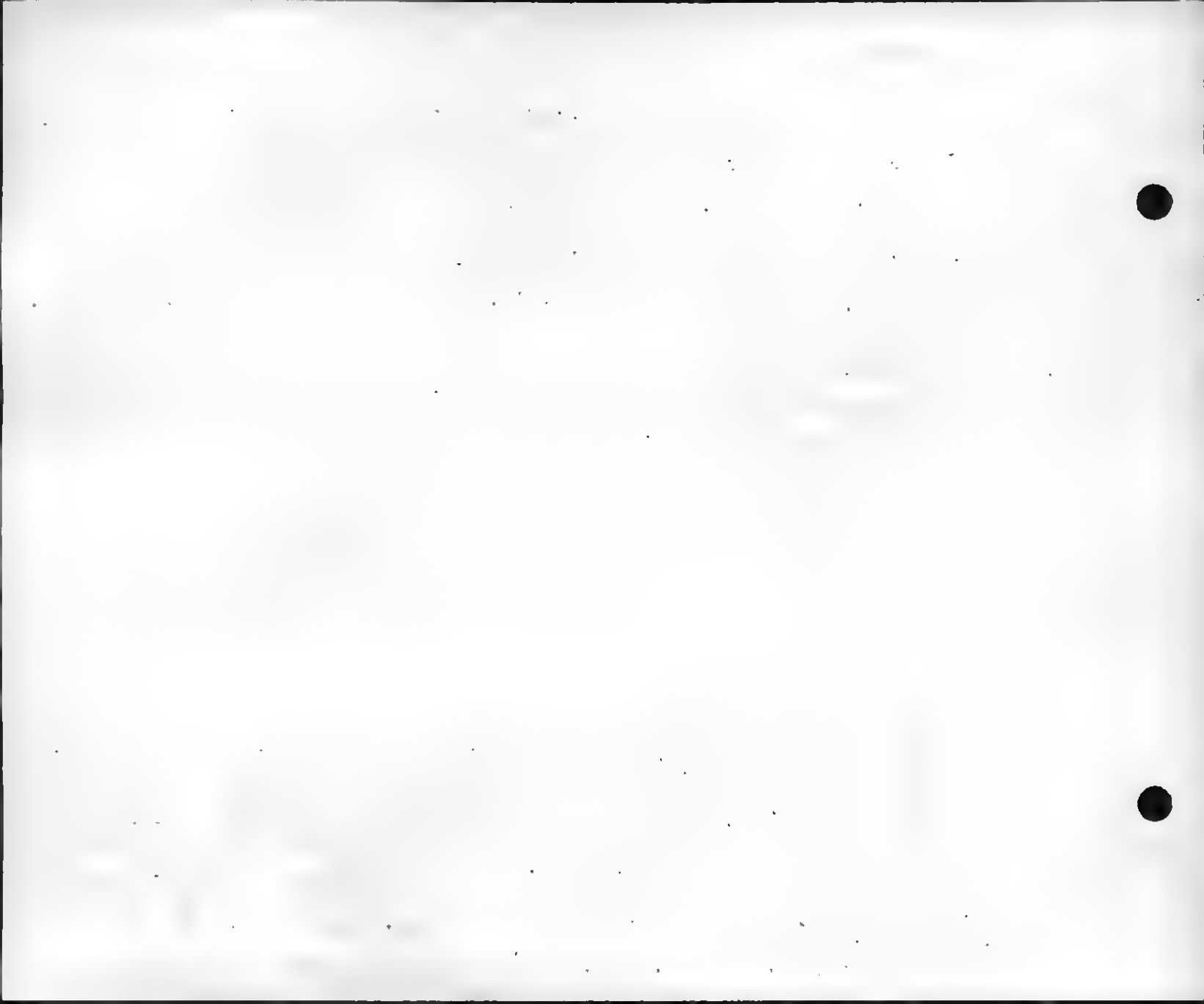


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH Month Day Year		2b HOUR 10:45 PM		
Emma			Dowdell		(Dowell)		December		6, 1968				
3 SEX female			4 RACE Negro			5 DATE OF BIRTH April 14, 1894			6 AGE (In years last birthday) 74 YRS		7c UNDER 1 YEAR MONTHS DAYS		
7a BIRTHPLACE (State or foreign country) Georgia			7b CITIZEN OF WHAT COUNTRY? U. S.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Baltimore		12b KIND OF BUSINESS OR INDUSTRY		
10 CITY OR TOWN OF DEATH Catonsville			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife			12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b COUNTY Balto.			13c CITY OR TOWN Balto.			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 147 North Monastery Ave.		
14 FATHER'S NAME Will Peterson			15 MOTHER'S MAIDEN NAME Harriett			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary embolism 7129 DUE TO, OR AS A CONSEQUENCE OF Congestive heart failure (b) DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic cardiovascular disease (c) 4221 Azotemia - Decubitus ulcers													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, EARM STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (X) (this hospital) attended the deceased from Sept. 20, 19 68, to Dec. 6, 19 68, that (I) (we) last saw the deceased alive on Dec. 6, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b SIGNATURE Diomidis Pirovolidis			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 12-6-68							
22d PHYSICIAN'S NAME (Type) Diomidis Pirovolidis, M.D.			22e ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228										
23a B. RIAL, CREMATION, REMOVAL (Specify) BURIAL			23b DATE 12-10-68			23c NAME OF CEMETERY OR CREMATORY Arbutus Memorial Pk. Baltimore, Maryland			23d LOCATION (City or Town) (County) (State)				
24 FUNERAL DIRECTOR Morton & Dyett Funeral Homes, Inc. 1701 Laurens St., Balto., Md. 21217			25a REC'D BY REGISTRAR DATE EC 9 1968			25b. REGISTRAR'S SIGNATURE J. Charles Judge							



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

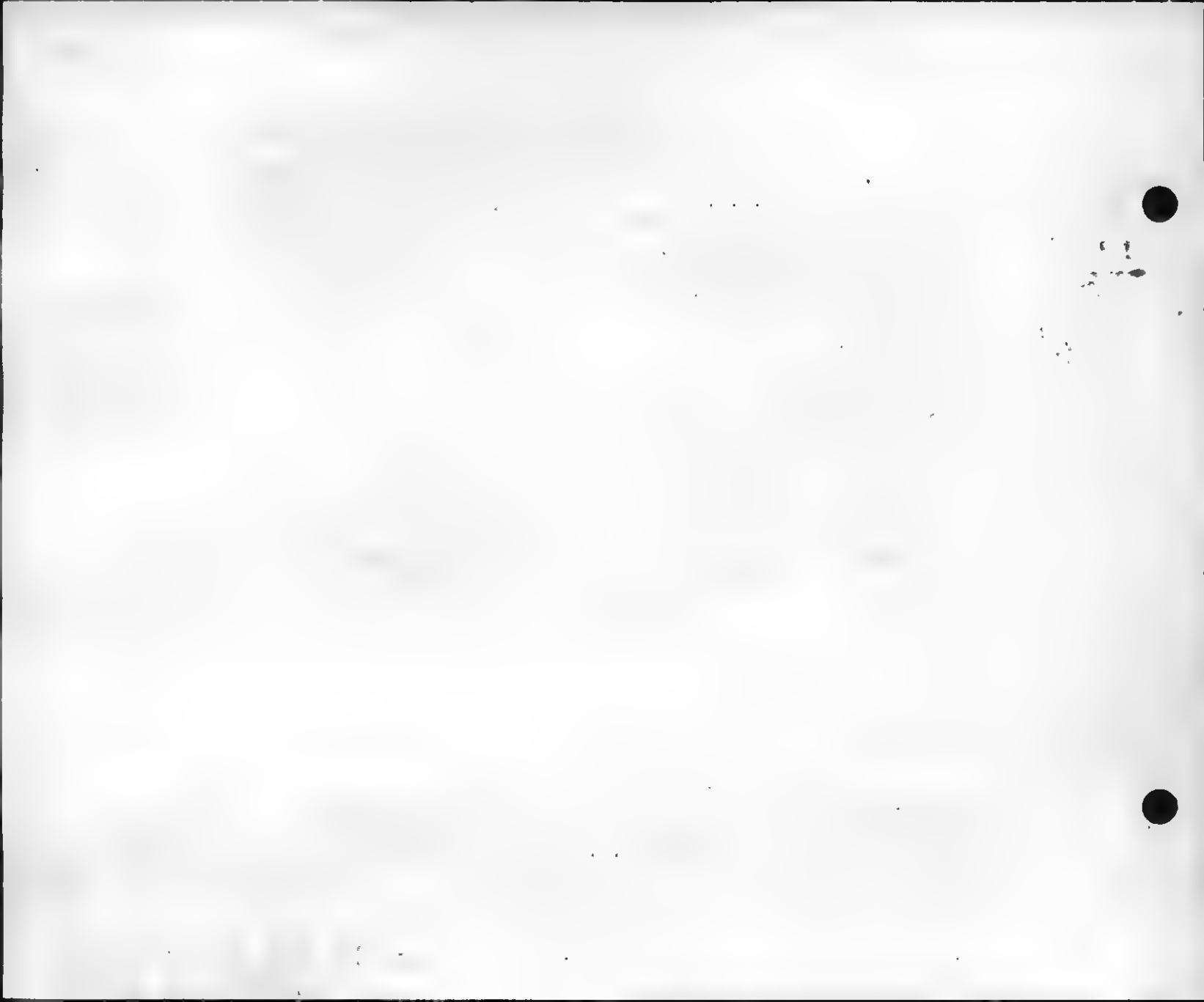
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17011

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17022

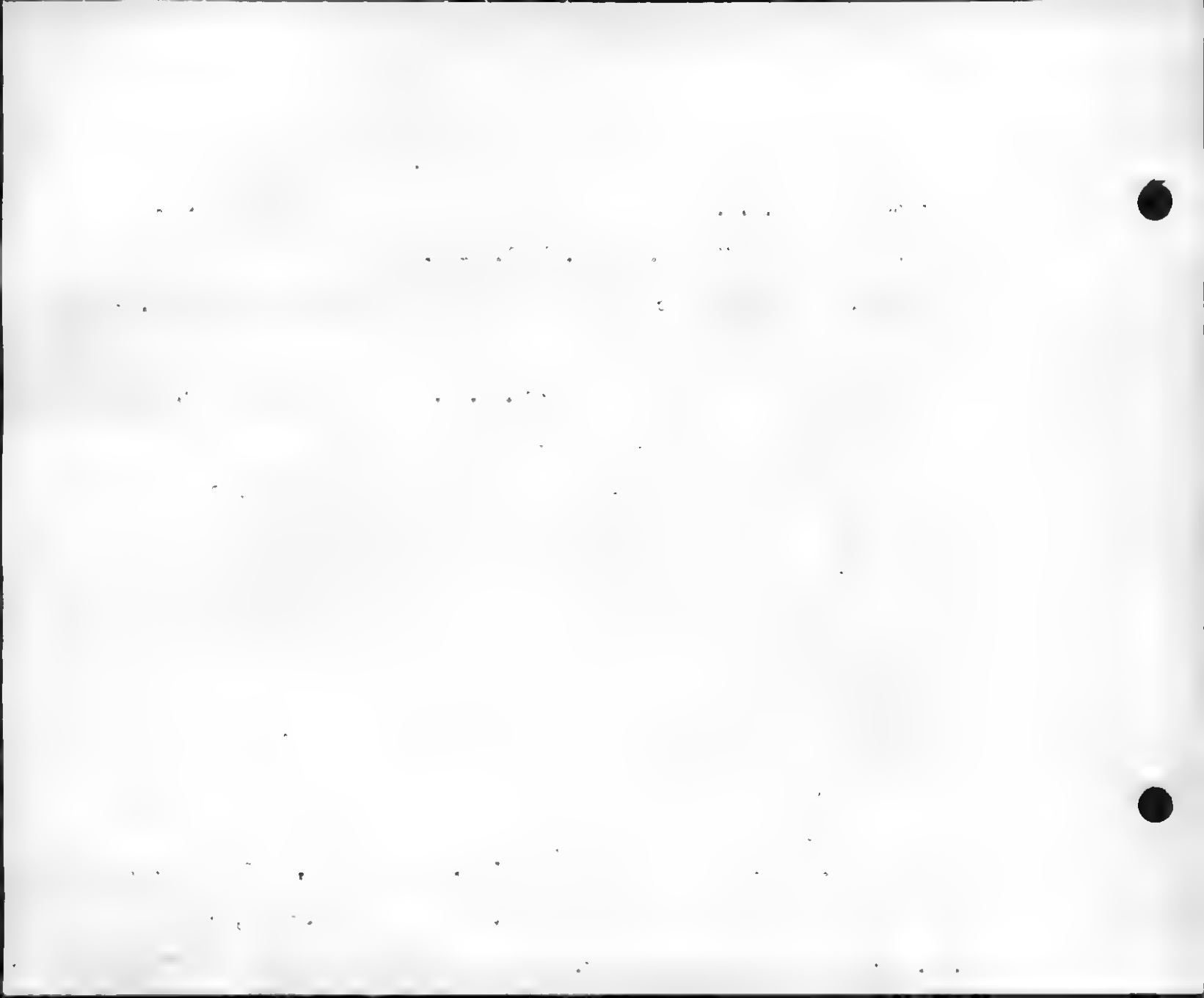
1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR					
JULIA VICKERS DOWELL						DATE ESTI- MATED <input checked="" type="checkbox"/>			19			M					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR			
female		white		2-28-1914		54 YRS		MONTHS DAYS		HOURS MIN		Month Day Year		10:30 A.M.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH								
Maryland			U.S.A.						Baltimore			Md					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY					
Timonium				420 Fox Chapel Road DRIVE				Housewife				Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE				13b. CITY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Maryland				Baltimore				Timonium				420 Fox Chapel Road DRIVE					
14. FATHER'S NAME First Middle Last						15. MOTHER'S MAIDEN NAME First Middle Last											
Albert Curtis Bowersock						Mildred Naudine Crawford											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS					
NO						217-50-1445						Mr. David L. Dowell 112 Belmore Road 21093					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Rheumatic Endocarditis, Inactive</u>																	
39779																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																	
DUE TO, OR AS A CONSEQUENCE OF (b)																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
414X																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>Werner J. Spitz</u>						M.D.						22b. DATE SIGNED					
EXAMINER'S NAME (Type)						Werner J. Spitz, M.D.						12/24/68					
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY					
Burial						12-27-1968						Dulaney Valley Memorial					
24. FUNERAL DIRECTOR						ADDRESS						25a. REC'D BY REG STRAR					
Wm. Cook-Brooks Towson						1050 York Rd. 21204						DEC 27 1968					
												25b. REG STRAR'S SIGNATURE					
												Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>17012</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 5 Film 3408 1/10/69 ts</div> <div>CERTIFICATE OF DEATH</div> <div>17023</div>															
1 DECEASED NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH		2b. HOUR				
THERESA			MARIE		DOYLE				12 Month 28 Day 68Year		3:15 PM				
3 SEX		4 RACE		5 DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER YEAR		IF UNDER 24 HRS			
FEMALE		WHITE		JULY 26, 1893				75 YRS		MONTHS DAYS		HOURS MIN			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH									
Canada		U.S.A.				BALTIMORE Co. Md									
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY						
TOWSON			GREAT. BALT. MED. CEN.												
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER						
Maryland			Baltimore						924 Dunellen Dr. 21204						
14. FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME First Middle Last						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17 INFORMANT Address									
						Mrs. W. J. Lane 924 Dunellen Dr. #21204									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION															
7109 DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)										
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (X) (this hospital) attended the deceased from 12-26, 1968, to 12-28, 1968, that (X) (we) last saw the deceased alive on December 28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b SIGNATURE										DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED 12-29-68	
22d PHYSICIAN'S NAME (Type) Dr. Rudiger Breiteneker M.D.										22e ADDRESS 6701 N. Charles St. 21204					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)							
Burial			12/31/68		Holy Hood Cem.			Brookline, Mass							
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE							
Wm. E. Johnson 8521 Loch Raven Blv. #21204						JAN 3 1969		Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 3 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with in 72 hours after death.

VR A15 10
45M - 109

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH		17024	
ROMAN J. DUMBROWSKI -		J.		DUMBR		OWSKI -		Month		Day	
DUMBR		OWSKI		OWSKI		OWSKI		DECEMBER		9	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		7a MONTHS		7b DAYS	
MALE		CAUCASIAN		OCTOBER 16, 1886		82 YRS.					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		12b KIND OF BUSINESS OR INDUSTRY		12c HOURS	
POLAND		U.S.A.				BALTIMORE		SHOE SHOP		MD	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		2a USUA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		12c HOURS		12d MIN	
FORT HOWARD, MD		HOSPITAL VETERANS ADMINISTRATION		SHOEMAKER							
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		13f ZIP CODE	
MARYLAND		BALTIMORE		BALTIMORE				3437 CLIFT MONT AVE			
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First	
THOMAS		DUMBR		OWSKI		ALEXANDRA		UNK.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		Address					
YES		213 34 1975		CLINICAL RECORDS, VA HOSPITAL, FT HOWARD, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA											
486X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
493X											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)		21f LOCATION Street or RFD No City or Town County State							
22a. I certify that (X) (this hospital) attended the deceased from 8/12/68, 19 to 12/9/68, 19, that (X) (we) last saw the deceased alive on 12/9/68, 19, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) did not view the body after death.											
22b SIGNATURE		V. Chitraplee		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED		12 9 68	
22d. PHYSICIAN'S NAME (Type)		VADHANA CHITRAPLEE, M.D.		22e ADDRESS		VA HOSPITAL, FORT HOWARD, MARYLAND					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
BURIAL		12-12-68		HOLY ROSARY'S CEMETERY		BALTIMORE, MARYLAND					
24 FUNERAL DIRECTOR		ADDRESS		25a RECD BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
WM FIALKOWSKI FUNERAL HOME, 2007 EASTERN AVE.		BALTO, MD		DEC 12 1968		Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
17014
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

18526

1. DECEASED-NAME (Type or print) First Middle Last Earl Vincent Dube			2a. DATE OF DEATH Month Day Year Dec. 12 1968			2b. HOUR 3:45 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 2 6-00		6. AGE (In years last birthday) 68 YRS.	
7a. BIRTHPLACE (State or foreign country) USA Rhode Island		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County, Md	
10. CITY OR TOWN OF DEATH Mount Wilson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson St. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Restaurant worker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last William A. Dube		15. MOTHER'S MAIDEN NAME First Middle Last Margaret Raddigan		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) None			
16b. SOCIAL SECURITY NO 577-22-2787		17. INFORMANT Address Records, Mt. Wilson State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ② Pulmonary Tuberculosis DUE TO, OR AS A CONSEQUENCE OF (b) ② Broncho Pleural fistula, Tuberculosis DUE TO, OR AS A CONSEQUENCE OF (c) ③ Cor pulmonale, decompensated. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs. 2 yrs. 1 yr.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ④ Emphysema, obstructive.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 7-20 , 19 67 , to 12-12 , 19 68 , that (I) (we) last saw the deceased alive on Dec. 12 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W Newcomer						22c. DATE SIGNED 12-12-68	
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.						22e. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Newell Funeral Home, Baltimore, Md.		ADDRESS		25a. RECEIVED BY REGISTRAR JAN 23 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

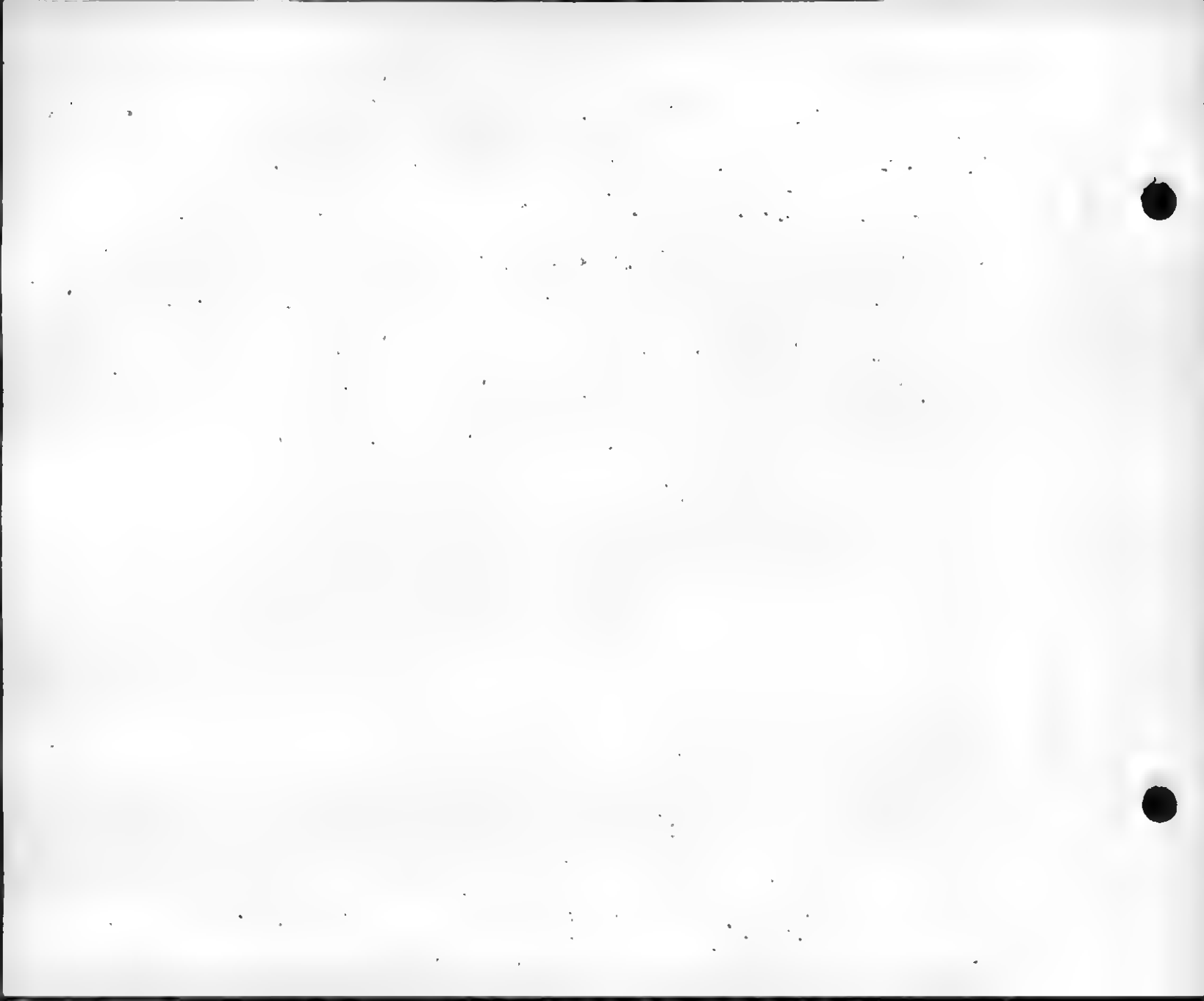


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

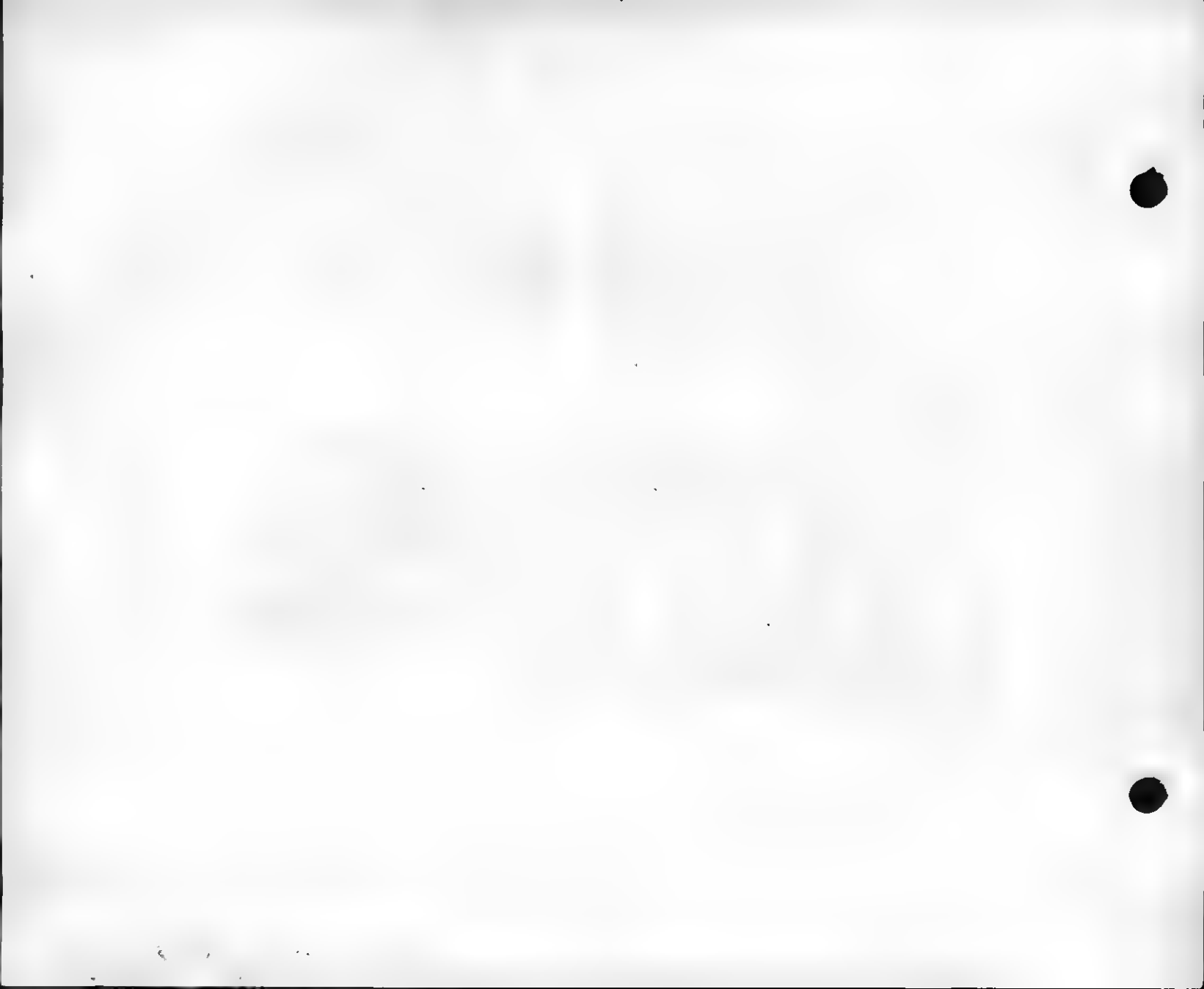
MEDICAL CERTIFICATE ON

17015				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17025			
1 DECEASED NAME (Type or print)				2a. DATE OF DEATH				2b. HOUR			
First Middle Last ANNA ARMSTRONG DUNLAP				Month Day Year 12 19 68				1:30 P M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		CAUCASIAN		OCT. 22, 1901		67 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
PENNA		BALTIMORE MD				BALTIMORE Md.					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
DUNDALK		2638 LIBERTY PKWY				HOUSEWIFE					
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
MD.		BALTIMORE		DUNDALK				2638 LIBERTY PKWY.			
14 FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
SAMUEL ARMSTRONG				MARY WHITEHEAD							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)				16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
NO				216-32-2847		A. JEANE ZACIERKA		AS IN #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident											
4100 DUE TO, OR AS A CONSEQUENCE OF (b) HCU											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or RFD No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 5/24, 19 68, to 12/19/68, that (I) last saw the deceased alive on 12/19/68, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED					
THEO. C. PATTERSON						12/20/68					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
THEO. C. PATTERSON		2427 Wendell		21212							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		12/23/1968		OAK LAWN		BALTIMORE CO., MD.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE					
W. Smith Rodley, Inc., Hgt				DEC 23 1968		J. Smith, Judge					



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers to pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17016		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		17026	
Item 13 Film 408 1/13/69 kk		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print) First Middle Last ELLA MAY DYE			2a. DATE OF DEATH 12 Month 31 Day 68 Year		2b. HOUR M
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH 5-7-1891		6 AGE (in years last birthday) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH BALTIMORE Md		
10 CITY OR TOWN OF DEATH COCKEYSVILLE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MASONIC HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, first full year Residence before admission) STATE MARYLAND COUNTY BALTIMORE		13b. CITY OR TOWN COCKEYSVILLE	13c. INSIDE CITY L.M.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 3913 Falls Rd. SHAWARD, 1968	
14 FATHER'S NAME First Middle Last GEORGE ESLEIN		15. MOTHER'S MAIDEN NAME First Middle Last CATHERINE BELL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO 212-07-4251 D	17 INFORMANT Masonic Home Records		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 174X Metastatic Carcinoma Breast. DUE TO, OR AS A CONSEQUENCE OF Adenocarcinoma Breast and Uterus. DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YRS 7 YRS.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 170X					
19a. DATE OF OPERATION 1961		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Adenocarcinoma Breast.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Dec. 1, 1968, to Dec. 31, 1968, that (I) (we) last saw the deceased alive on Dec. 31, 1968, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE Carl F. Benson M.D.		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) Carl F. Benson M.D.		22e. ADDRESS 5111 York Rd. Balt. Md 21212			
23a. BURIAL, CREMATION, OR OTHER DISPOSAL BURIAL		23b. DATE JAN 3, 1969		23c. NAME OF CEMETERY OR CREMATORY FOPLAR GROVE	
23d. LOCATION (City or Town) (County) (State) BALTO. CO MD					
24. FUNERAL DIRECTOR Wm Cook-Brooks Townsm		ADDRESS 1800 York Rd Towson, Md 21204		25a. REC'D BY REGISTRAR DATE JAN 3 1969	
		25b. REGISTRAR'S SIGNATURE Charles Judge			



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VR 415
304 REV

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) First Middle Last ARTHUR NMN ECKHARDT			2a. DATE OF DEATH DEC Month 31 Day 68 Year			2b. HOUR 5 MIN 15			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH Feb. 1, 1892.		6. AGE (In years last birthday) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE		Md	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or in residence) DR. BALTO. MED. CENTER		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clothier		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2805 Overland Avenue	
14. FATHER'S NAME First Middle Last Gusta Eckhardt			15. MOTHER'S MAIDEN NAME First Middle Last Minna Ninehart						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 215-09-1795A		17. INFORMANT Mrs. Lillian M. Eckhardt		Address (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA 401X DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. (b) BRONCHO PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12-20 , 19 68 , to 12-31 , 19 68 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Gregorio B. Pastoride</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-31-68			
22d. PHYSICIAN'S NAME (Type) GREGORIO PASTORFIDE, MD.				22e. ADDRESS 6701 N. CHARLES ST. BALTO. MD 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/3/69.		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				ADDRESS 21214		25a. REC'D BY REGISTRAR JAN 2 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

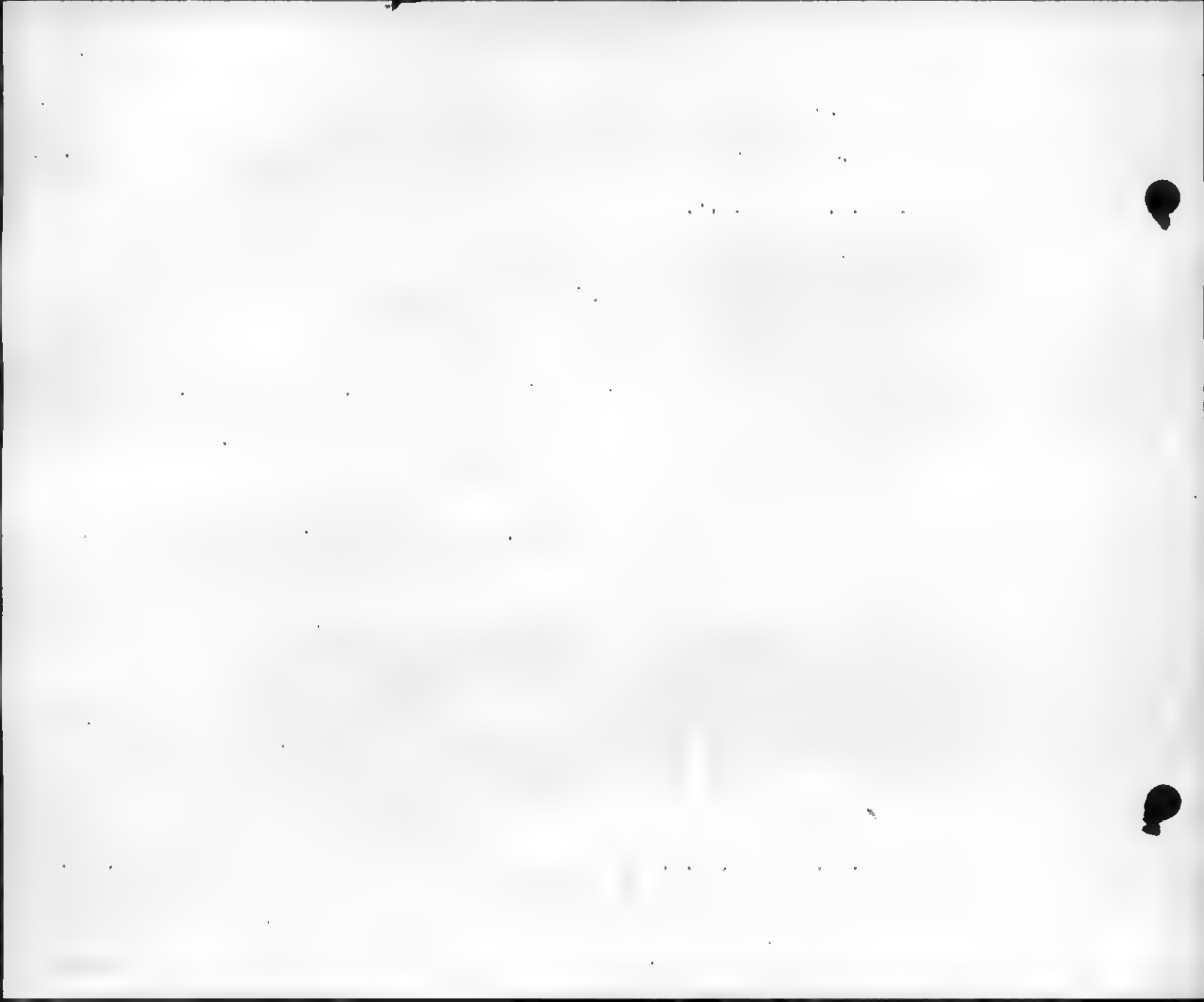
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17018

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17028

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI DEATH			Month Day Year			2b HOUR			
Bernard			-			EDMONDS			12 3 1968			4:30 ^a			
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD			2d HOUR				
Male	Negro	9/20/59	9 YRS					12 3 1968			4:30 ^a				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH									
Wash., D.C.		U.S.A.				Baltimore Md.									
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY						
Owings Mills			Rosewood State Hospital			Dependent			None						
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY			13c CITY OR TOWN			3d INSIDE CITY LIMITS?			13e STREET AND NUMBER			
Maryland			Prince Geo. District Heights			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			2101-71st Avenue						
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES?			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS			
Jasper Lee Edmonds			Mina - Swint			no			none			Rosewood Records, Owings Mills, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Arrest due to Aspiration of Bronchial</u> 940X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Secretions.</u> Traumatic Encephalopathy (c) <u>Cerebral Contusion. Convulsive Disorder due to B.</u> 3 yrs. 4 mos. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 160X												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days			
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?									
7/17/65			Trepines and Tracheostomy			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b TIME OF INJURY Month Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
CAUSE OF DEATH			HOUR A.M. P.M.			Car Accident									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f LOCATION Street or R.F.D. No.			City or Town			County		State	
												Virginia?			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
D. D. Caples			D. D. Caples, M.D.									22b DATE SIGNED			
												12/3/68			
												ADDRESS (Street, city, town, or county)			
												Reisterstown, Md.			
23a BURIAL CREMATION REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town)			(County) (State)			
Burial			12/7/68			Harmony Memorial Park			Maryland						
24 FUNERAL DIRECTOR			25a REC'D BY REG. STRAR			25b REGISTRAR'S SIGNATURE									
Stewart			John H. Stewart			DEC 6 1968			J. Charles Judge						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

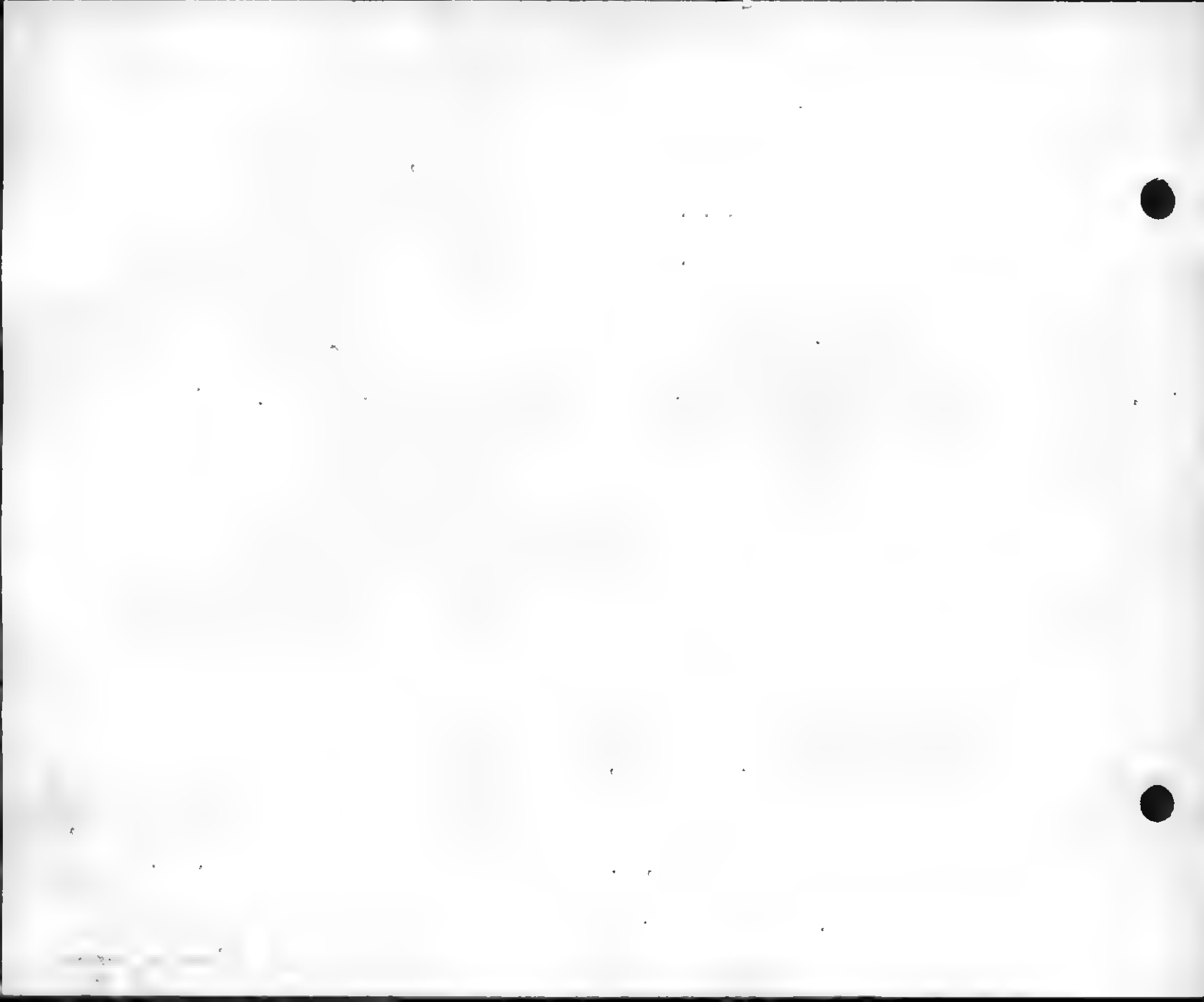
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17019

CERTIFICATE OF DEATH

17029

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b. HOUR	
ADOLPH		WILLIAM	EIRING	DECEMBER 23, 1968		5:10AM		
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE	WHITE	MARCH 23, 1895		73 YRS				
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		12b KIND OF BUSINESS OR INDUSTRY		
MARYLAND	U.S.A.			BALTIMORE,				
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of work-life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
TOWSON		ST. JOSEPH HOSPITAL		CONTINENTAL CAN CO.				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MARYLAND				BALTIMORE				
14 FATHER'S NAME First Middle Last		15 MOTHER'S M.A.D.E.N NAME First Middle Last		13e STREET AND NUMBER		13f ZIP CODE		
UNKNOWN		UNKNOWN		2124 BANK STREET		#21231		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT		Address		
NO		216-03-3720		ROSE EIRING		2124 BANK ST		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) EPIDERMOID CARCINOMA of the RIGHT LUNG								
162.1 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								
(b) DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1B.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State				
22a I certify that (X) (this hospital) attended the deceased from November 23, 1968, to December 23, 1968, that (X) (we) last saw the deceased alive on December 23, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death.								
22b SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED		
X						December 23, 1968		
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS		22f ADDRESS				
Eugenio Antonio, M.D.		7620 York Road		Towson, Md. #21204				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
BURIAL		12-26-68		OAKLAWN CEM.		BALTO. MD.		
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
JOHN M. WEBER & SONS INC		401 S. CHESTER ST		DATE DEC 24 1968		Charles Judge		

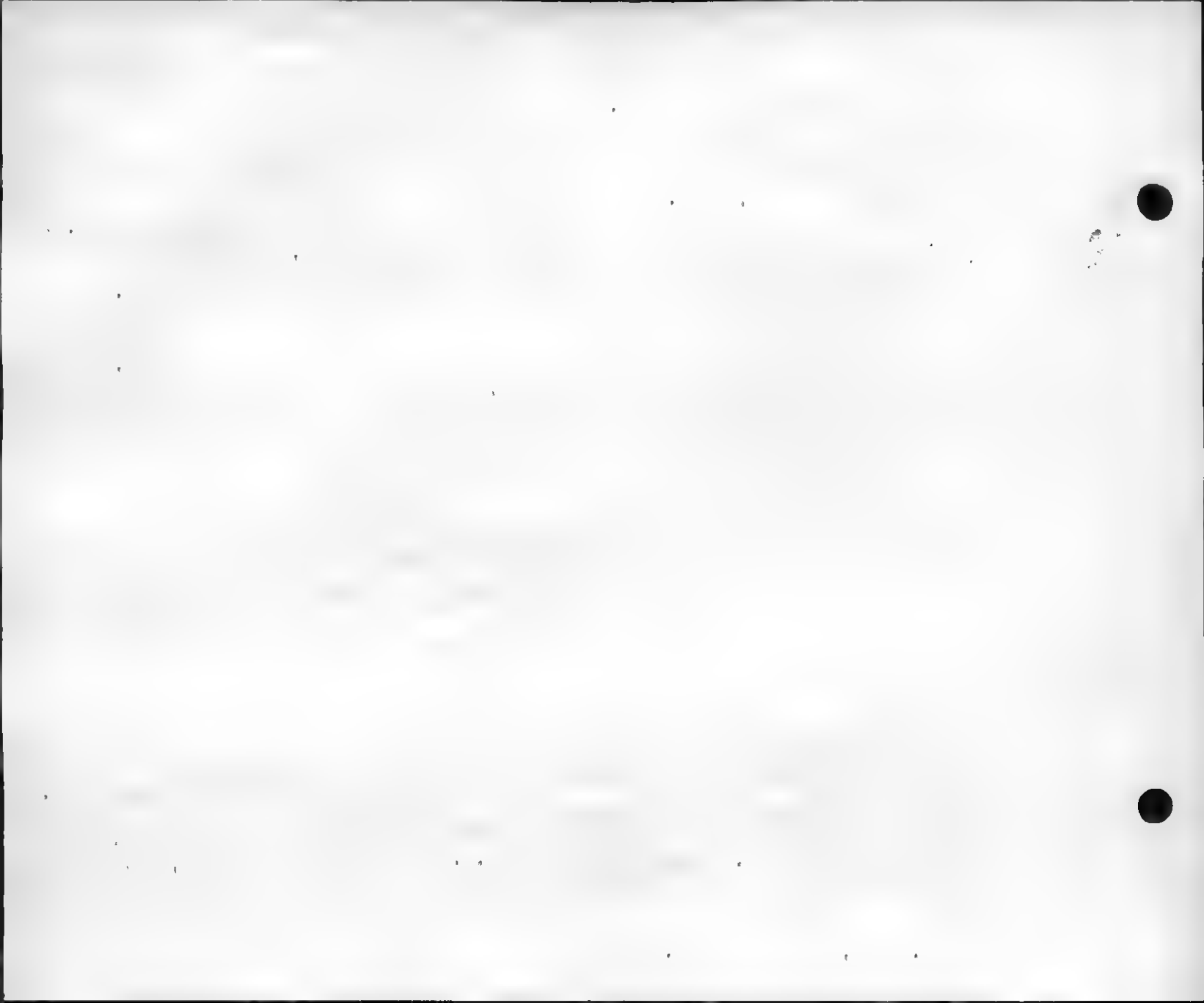


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
Robert			H. Ellingson			Month Day Year			19		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER YEAR		7 UNDER 24 HRS	
Male		White		7/18/11		57 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Maryland			U. S. A.						Baltimore		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Dundalk			1766 Melbourne Road			Conductor, Patapsco & Back River					
13a USUA. RESIDENCE (Where deceased lived if institution admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
Maryland			Baltimore			Dundalk			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		
Hans			Lena Bernstein			No			215-07-6259		
17 INFORMANT (Wife)			ADDRESS			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Mrs. Mary C. Ellingson, 1766 Melbourne Rd.			Dundalk, Md.			4109					
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			19								
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town		
									County		
									State		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b DATE SIGNED					
Theodore C. Patterson			M.D.			Dec. 16, 1968					
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)					
Theodore C. Patterson			M.D.			Dundalk, Md. 21222					
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			12/17/68			Oak Lawn Cemetery			Baltimore, Maryland		
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
John J. Duda, 7922 Wise Ave. Dundalk, Md.						DEC 23 1968			J. Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17021

CERTIFICATE OF DEATH

17031

1. DECEASED NAME (Type or print) HYMAN			First Middle Last			2a. DATE OF DEATH Month DECEMBER Day 2 Year 1968			2b. HOUR 9:20 P.M.		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 12-28-1891			6. AGE (In years last birthday) 76 YRS.		
7a. BIRTHPLACE (State or foreign country) RUSSIA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE Md.		
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MILFORD MANOR NURSING HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) TAILOR			12b. KIND OF BUSINESS OR INDUSTRY RETIRED		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last UNKNOWN EPSTEIN			15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		
17. INFORMANT Address MRS. ANNE BASS, 5715 JONQUIL AVENUE #21215			18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) arteriosclerotic Heart Disease +107 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) none DUE TO, OR AS A CONSEQUENCE OF (c) none			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 29 , 19 65 , to Dec 2 , 19 68 , that (I) (we) last saw the deceased alive on Dec 2 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Manuel Levin			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 12/3/68		
22d. PHYSICIAN'S NAME (Type) MANUEL LEVIN			22e. ADDRESS 6101 PARK HEIGHTS AVENUE								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 12-3-68			23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			ADDRESS			25a. REC'D BY REGISTRAR DEC 6 1968			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

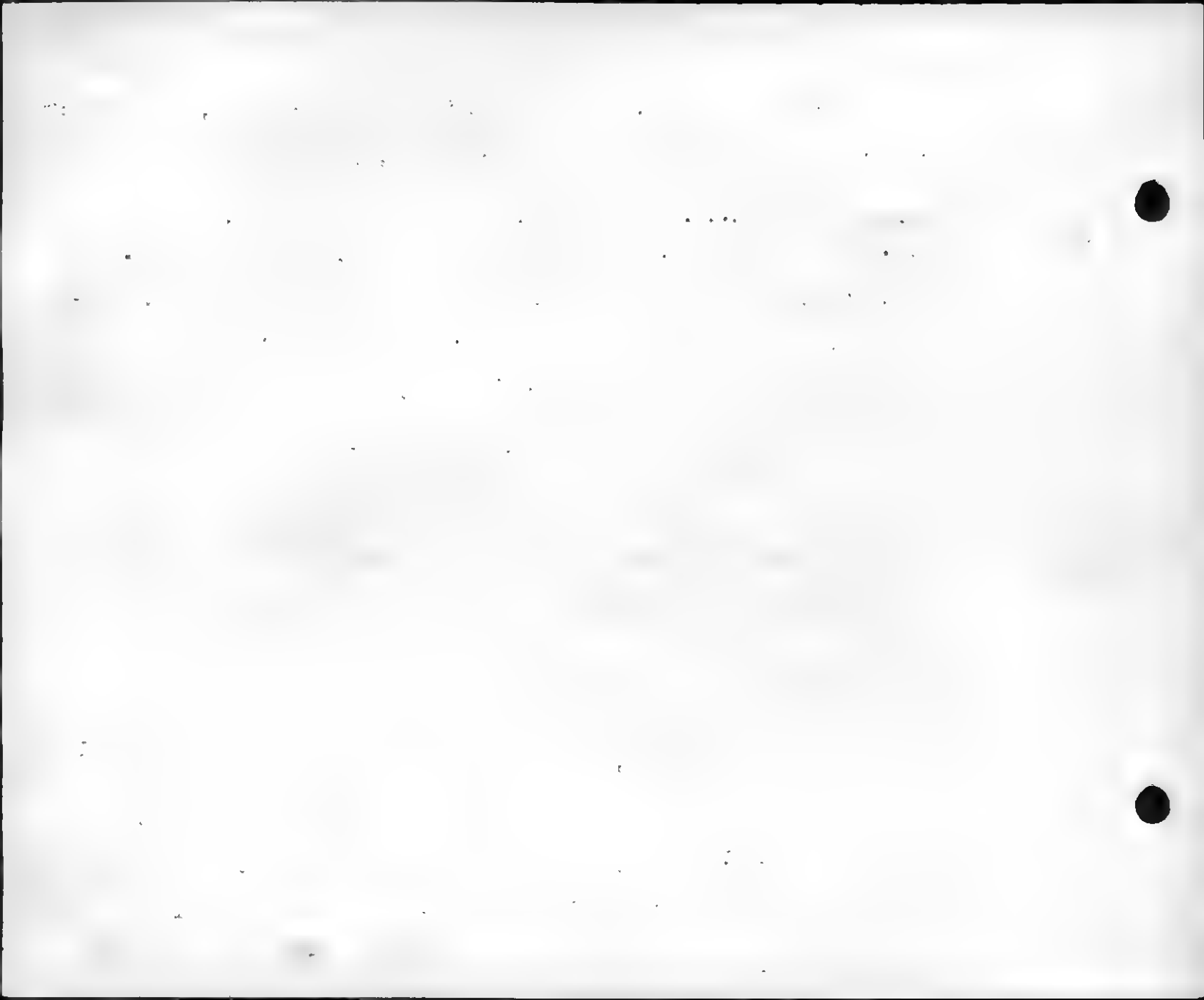


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VR A15 (4)
30M REV 1/68

<div style="display: flex; justify-content: space-between;"> 17022 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17032 </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>											
1 DECEASED-NAME (Type or print)		First MARIE		Middle E.		Last EVERETT		2a DATE OF DEATH Month 3 , Day 1968		2b HOUR 4:00AM	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH FEBRUARY 24, 1896		6 AGE (In years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE, Md					
10 CITY OR TOWN OF DEATH TOWSON		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) ST. JOSEPH HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOME MAKER		12b KIND OF BUSINESS OR INDUSTRY HOME					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b COUNTY BALTIMORE		13c CITY OR TOWN BALTIMORE		13d INSIDE CITY LIM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 3301 NORMAN AVE. #21213			
14 FATHER'S NAME First Middle Last PETER GRANLUND				15. MOTHER'S MAIDEN NAME First Middle Last BRIDGET McDEVITT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO.		17 INFORMANT Address Mrs. Donna Stangan - 3301 Norman Ave.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of pancreas with extensive metastasis 157.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 157X											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (1) (this hospital) attended the deceased from November 16 1968 , to December 3 1968 , that NO (we) lost saw the deceased alive on December 3, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b SIGNATURE Ines Cilliani		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED 12/3/68					
22d. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D.		22e ADDRESS 7620 York Rd., Towson, Md. 21204									
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 12-6-68		23c NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEM.		23d LOCATION (City or Town) BALTO., Md		County		State	
24 FUNERAL DIRECTOR Ines Cilliani		ADDRESS 2334 E. ...		25a. REC'D BY REGISTRAR DEC 6 1968		25b. REGISTRAR'S SIGNATURE J. Santos Judge					

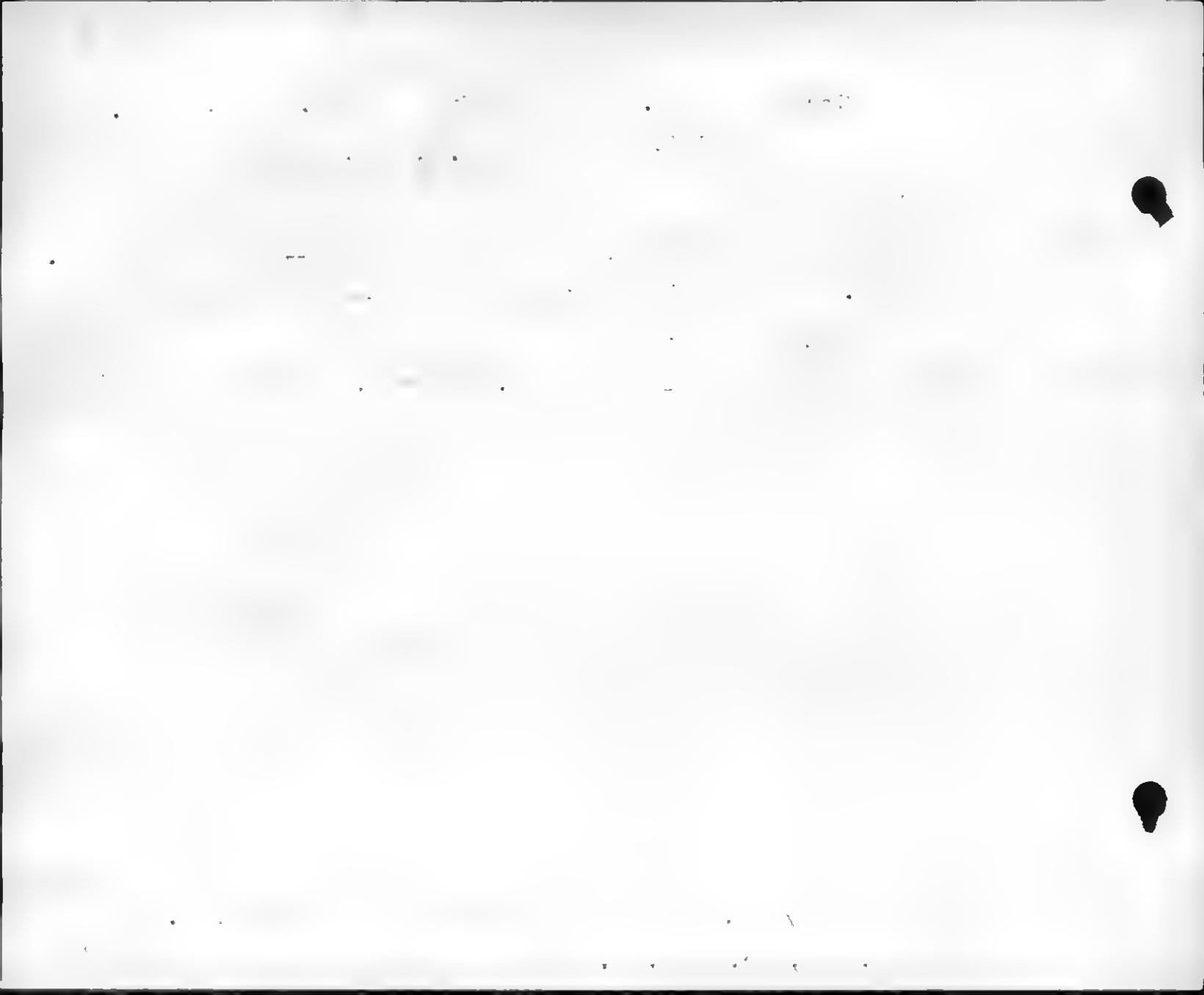


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH	2b. HOUR	
Charles J. Fabiszak					Dec. Month 5, Day 1968.	3:31 PM	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)	IF UNDER 1 YEAR	
Male	White	Oct. 8, 1920.			48 YRS.	MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland	USA			Baltimore Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson		8609 Drumwood Road		Accountant--Roofing Products Co.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY - NITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
Md.		Baltimore	Baltimore		8609 Drumwood Road		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		
Joseph Fabiszak					Mary Seifert		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name (unknown) [If you give name or dates of service]		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
Yes		215-14-9802		Mrs. Margaret C. Fabiszak		(Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION							
4109 DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE							2 YRS
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
4201 DIABETES MELLITUS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Mat while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1966, to Dec 5, 1968, that (I) (we) last saw the deceased alive on 2/17/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William A. Pilsbury				DEGREE ATTENDING PHYS MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 12-6-68	
22d. PHYSICIAN'S NAME (Type) William A. Pilsbury				22e. ADDRESS Timonium Md.			
23a. BURIAL, CREMATON, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		12/9/68.		Dulaney Valley Cemetery		Baltimore, Md.	
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
Leonard J. Ruck, Inc. Balto. Md. 21214				DEC 6 1968		[Signature]	



17024

CERTIFICATE OF DEATH

17034

1 DECEASED NAME (Type or print) Rebeckah		First Mozell	Middle Featherston	Last N	2a DATE OF DEATH 12 Month 18 Day 68 Year		2b HOUR 11 M		
3 SEX Female		4 RACE White		5 DATE OF BIRTH 2-23-89		6 AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (State or foreign country) Alabama		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10 CITY OR TOWN OF DEATH Randallstown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto Co Gen Hosp		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Certified Public Acc.		12b KIND OF BUSINESS OR INDUSTRY Self-employee			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b COUNTY Balto		13c CITY OR TOWN Randallstown		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 14 Church Road	
14. FATHER'S NAME First Lawrence		Middle Wilson		Last Agnes		15. MOTHER'S MAIDEN NAME First Scott		Middle Scott	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b SOC SEC SECURITY NO. 215074925		17 INFORMANT Spouse Thomas Featherston		Address 11 Church Rd ownmills			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) Multiple Myeloma DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 8 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
9a. DATE OF OPERATION None		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED None			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) None					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE, BUILDING, ETC		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from May 10, 1968 , to Dec 18, 1968 , that (I) (we) last saw the deceased alive on Dec 18, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b SIGNATURE Martin J. Feldman MD		DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 12-18-68			
22d. PHYSICIAN'S NAME (Type) Martin J. Feldman MD		22e ADDRESS Cherry Hill Rd Rosterstown MD 21136							
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b DATE Dec. 19, 1968		23c NAME OF CEMETERY OR CREMATORY Loudon Park Crematory		23d LOCATION (City or Town) Baltimore City		(County) (State) Md.	
24 FUNERAL DIRECTOR Loring Byers Chaple		ADDRESS 8728 Liberty Road		25a. REC'D BY REGISTRAR DEC 23 1968		25b REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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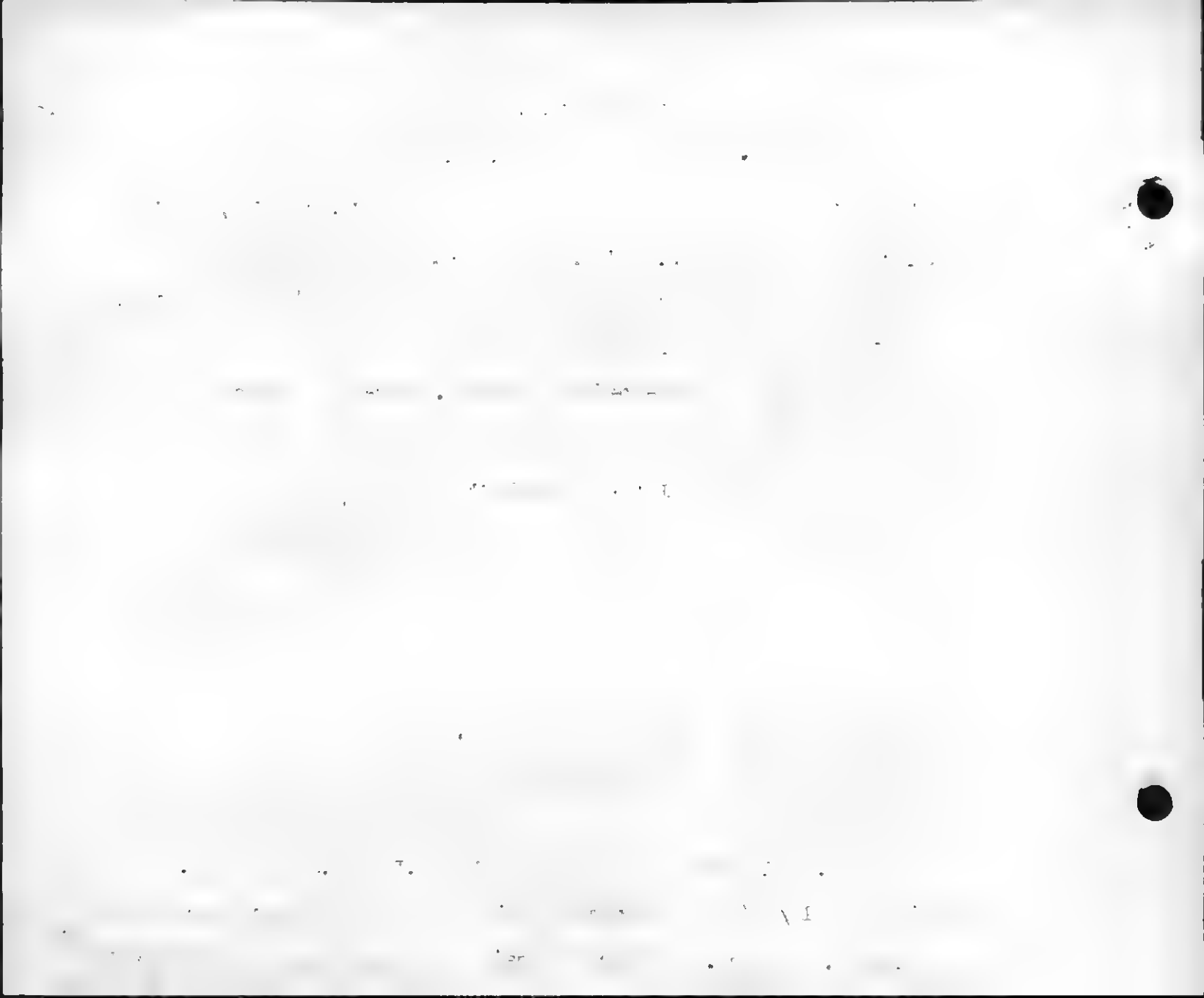
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17025

CERTIFICATE OF DEATH

17035

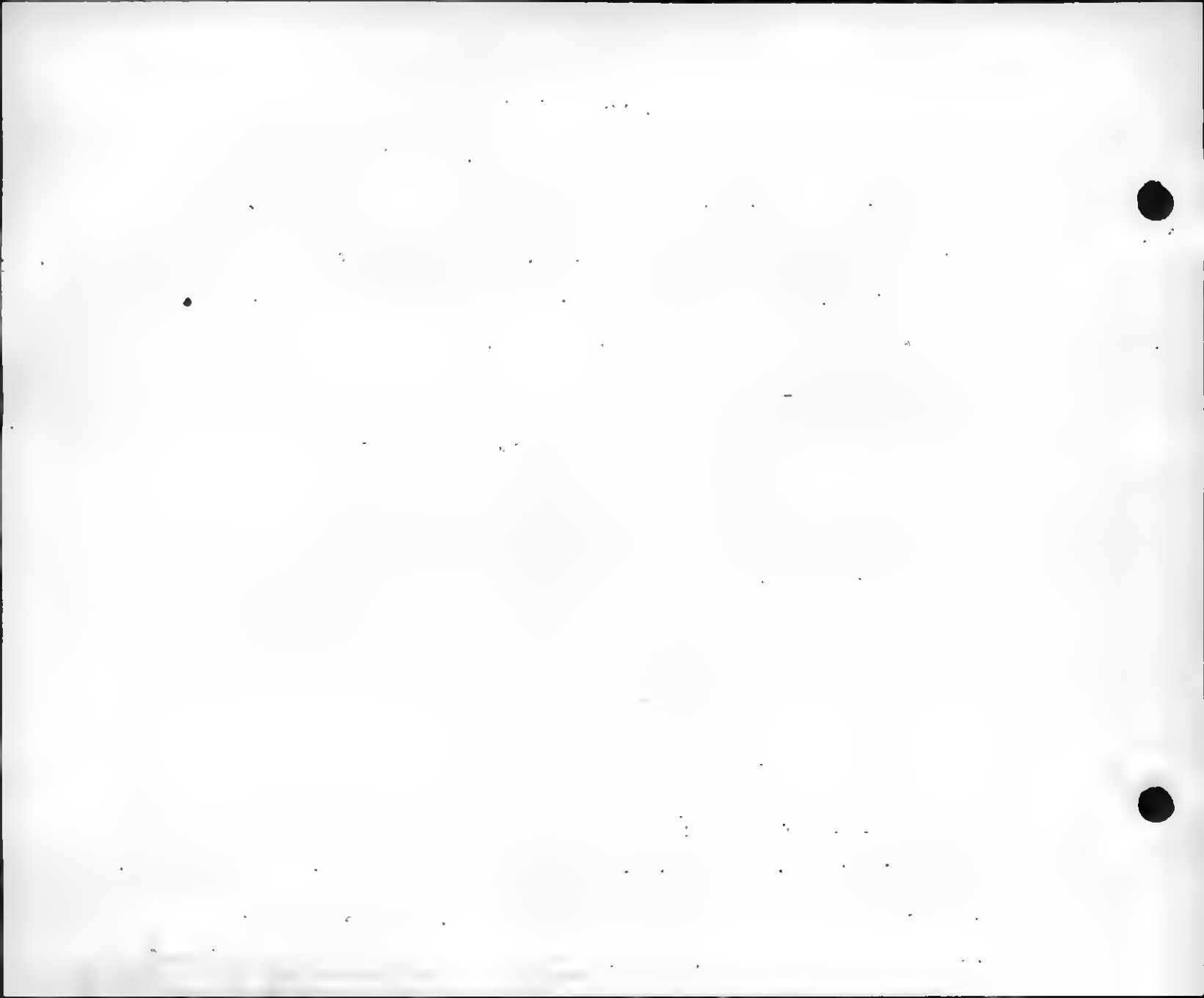
1. DECEASED NAME (Type or print) First Middle Last HORACE PRICE FERRELL			2a. DATE OF DEATH Month Day Year 12 26 68			2b. HOUR 7:30	
3. SEX MALE		4. RACE CAU.		5. DATE OF BIRTH 8-16-17		6. AGE (In years lost birthday) 51 YRS	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE, COUNTY Md	
10. CITY OR TOWN OF DEATH BALTIMORE, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREAT BALTO. MED. CENTR.		12a. USUAL OCCUPATION (Kind of work done during last working period and retired) ELECTRIC INSPECTOR		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY USA		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 215 Linhigh Avenue		14. FATHER'S NAME First Middle Last PRITCHARD FERRELL		15. MOTHER'S MAIDEN NAME First Middle Last LILLIAN CROUCH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 231-12-1598		17. INFORMANT Leona P. Ferrell		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MULTIPLE MYELOMA DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 19 68 , to 12/26 19 68 , that (I) (we) last saw the deceased alive on 12/26 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Dr. J. Mussiva</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED 12-26-68	
22d. PHYSICIAN'S NAME (Type) DR. MUSSIVA		22e. ADDRESS GREAT BALTO. MED. CENTR.					
23a. BURIAL, CREMATION, REBURNING (Type) Burial		23b. DATE 12/30/68		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Road				25a. REC'D BY REGISTRAR DEC 27 1968		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="display: flex; justify-content: space-between;"> 17036 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17036 </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>												
1 DECEASED-NAME (Type or print) ARTHUR				First H. ope Middle FILANDER Last				2a DATE OF DEATH Month 12 Day 30 Year 1968			2b HOUR 1:40 PM	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH Feb. 4, 1904			6 AGE (In years last birthday) 64 YRS		7 UNDER 1 YEAR MONTHS 0 DAYS 0		7 UNDER 24 HRS HOURS 0 MIN 0	
7a BIRTHPLACE (State or foreign country) Penna.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md						
10 CITY OR TOWN OF DEATH Towson, Md.			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center			12a USJA OCCUPATION (Kind of work done during most of working life, even if retired) Engineer			12b KIND OF BUSINESS OR INDUSTRY			
13a USJA RESIDENCE (Where deceased lived, if institution Residence before admssion) STATE Maryland				13b COUNTY Baltimore		13c CITY OR TOWN 21212		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 720 Anneslie Road		
14 FATHER'S NAME First Andrew Middle Filander Last				15 MOTHER'S MAIDEN NAME First Sabina Middle ?????????? Last								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)				16b SOCIAL SECURITY NO 290-07-2074		17 INFORMANT Address Mrs. Corrine H. Filander, Same as # 13						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute bronchopneumonia, bilateral 400 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Y/X Diffuse pulmonary emphysema												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State								
22a I certify that (I) (this hospital) attended the deceased from 12/30 , 19 68 , to 12/30 , 1968, that (I) (we) last saw the deceased alive on 12/30 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE John E. Adams								DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED 12/30/68		
22d. PHYSICIAN'S NAME (Type) John E. Adams, M. D.								22e. ADDRESS Greater Baltimore Medical Center				
23a BURIAL, CREMATION, ENTOMBMENT		23b DATE Jan. 2, 1969		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Mausoleum, Cockeysville, Maryland				23d LOCATION (City or Town) (County) (State)				
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204						25a REC'D BY REGISTRAR DATE JAN 3 1969		25b REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Item 7 Film 408 12/31/68 K

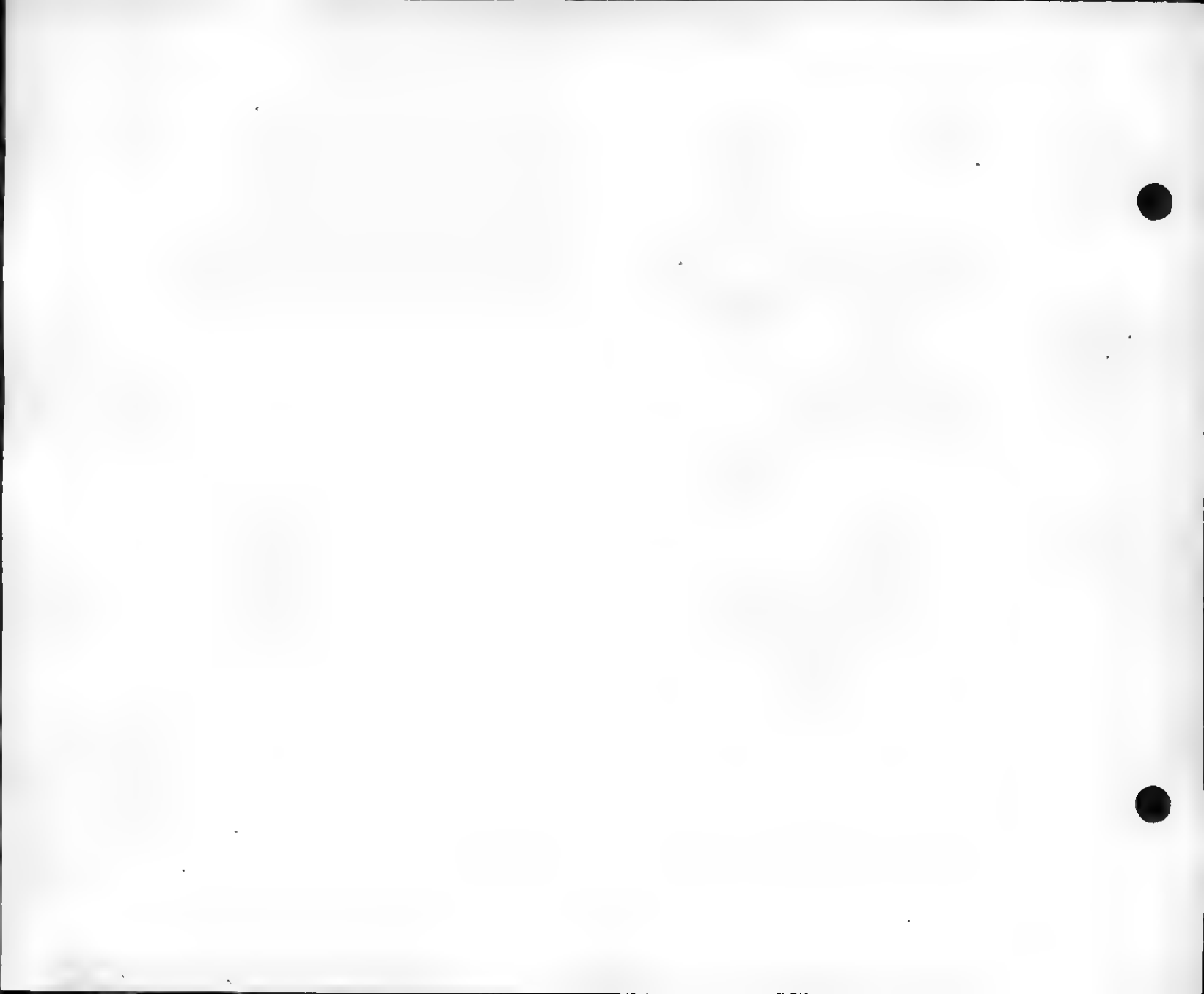
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17027

CERTIFICATE OF DEATH

17037

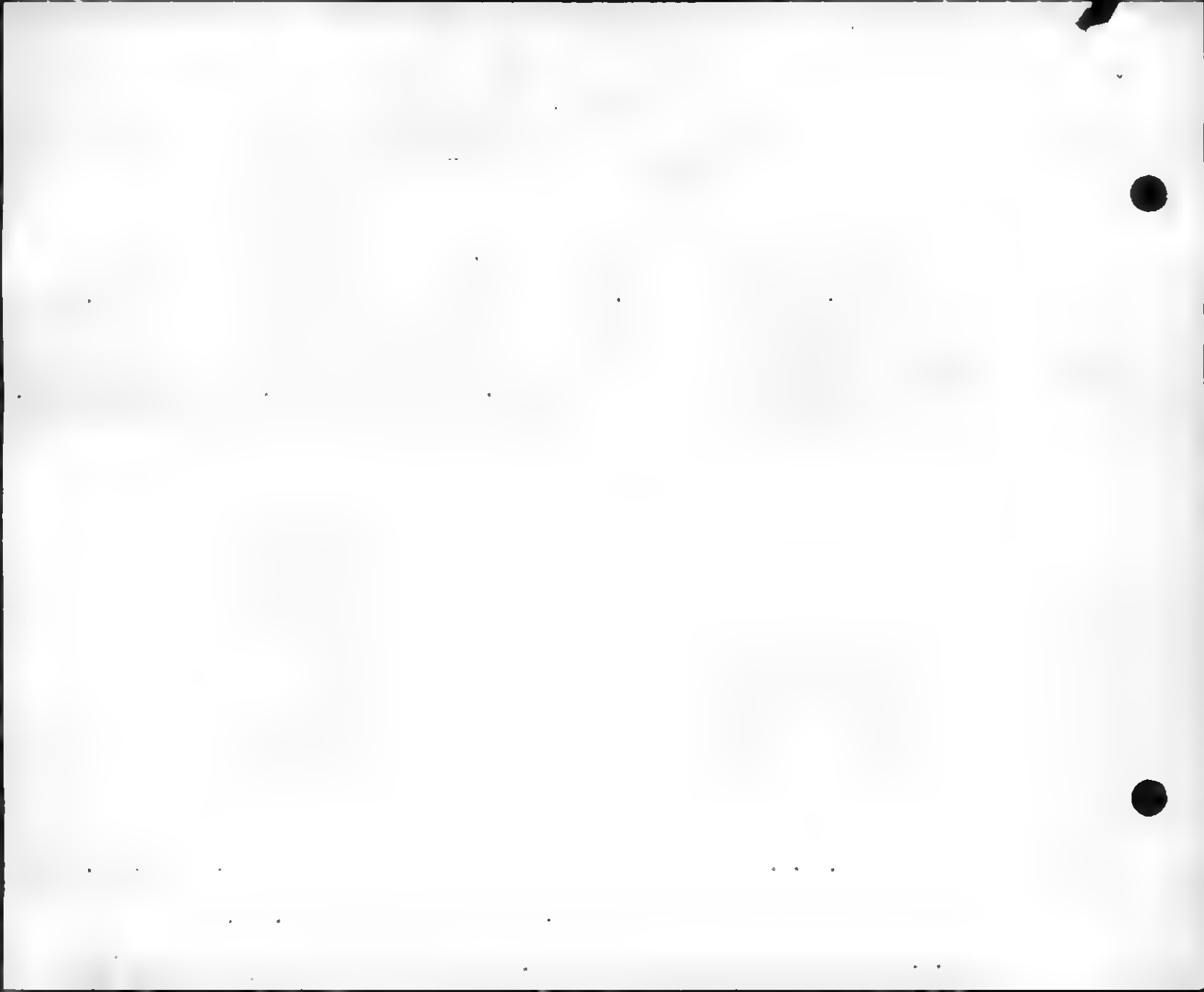
1 DECEASED NAME (Type or print) Angelina			First Middle Last FIOROLI			2a DATE OF DEATH Month 12 Day 16 Year 1968			2b HOUR 7:40 AM		
3 SEX Female			4 RACE White			5. DATE OF BIRTH January 10, 1903			6 AGE (In years lost birthday) 65 YRS		
7a BIRTHPLACE (State or foreign country) Italy			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore, Md.		
10 CITY OR TOWN OF DEATH Towson			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker			12b KIND OF BUSINESS OR INDUSTRY		
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b COUNTY Baltimore			13c CITY OR TOWN Baltimore			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e STREET AND NUMBER 27 Cockpit St.			14 FATHER'S NAME First Middle Last Bucci			15. MOTHER'S MAIDEN NAME First Middle Last ? ? ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b SOCIAL SECURITY NO			17 INFORMANT ARTHUR FIOROLI			Address ABOVE		
18. CAUSE OF DEATH (Enter on y one cause per line for (a) (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction sec. to 4109 Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. 4201 DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery thrombosis DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Pulmonary infarction											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b: If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or RFD No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/1/ , 19 68 , to 12/16/ , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/16/ , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>Christina Feliciano</i>			DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c DATE SIGNED 12/16/68					
22d. PHYSICIAN'S NAME (Type) Christina Feliciano, M.D.			22e ADDRESS 7620 York Rd., Towson, Md. 21204								
23a B. URIAL, CREMATION REMOVAL (Specify) BURIAL			23b DATE 12/19/68			23c NAME OF CEMETERY OR CREMATORY ST. STASIS LAUS			23d LOCATION (City or Town) (County) (State) BALTO. M.D.		
24 FUNERAL DIRECTOR J.E. CONNELLY SONS			ADDRESS 300 MACE			25a REC'D BY REGISTRAR DEC 19 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17028										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 10 Film 408 1/6/69 kk										CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH									
Eva E Fleischmann										Month 12 Day 24 Year 68 9:30 P									
3. SEX Female										4. RACE White									
5. DATE OF BIRTH 12-31-95										6. AGE (In years lost birthday) 72 YRS.									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? USA									
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Baltimore Md.									
10. CITY OR TOWN OF DEATH Baltimore										11. NAME OF HOSPITAL (If not in hospital give street address) 8020 Ridgely Oak Rd.									
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife										12b. KIND OF BUSINESS OR INDUSTRY Home									
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE Md.										13b. CITY OR TOWN Balto.									
13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13d. STREET AND NUMBER 21234 8020 Ridgely Oak Rd.									
14. FATHER'S NAME First Middle Last Nicholas Sebourn										15. MOTHER'S MAIDEN NAME First Middle Last Johanna Siefert									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO										16b. SOCIAL SECURITY NO.									
17. INFORMANT Mrs. Louis Steinbacher, 8020 Ridgely Oak Rd.										Address 21234									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE																			
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE																			
DUE TO, OR AS A CONSEQUENCE OF (c) DIABETE MELLITUS																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 260X																			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1968									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)									
21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from November 19, 1968, to Dec 24, 1968, that (I) (we) lost the deceased alive on Dec 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Larry S. Tilley M.D. DEGREE										22c. DATE SIGNED 12-26-68									
22d. PHYSICIAN'S NAME (Type) Dr. L.G. Tilley										22e. ADDRESS 1713 Taylor Avenue, Balto. Md.									
23a. BURIAL CREMATION REMOVAL (Type) Burial										23b. DATE 12-28-68									
23c. NAME OF CEMETERY OR CREMATORY Sacred Ht. Jesus										23d. LOCATION (City or Town) (County) (State) Balto. Co. Maryland									
24. FUNERAL DIRECTOR W.E. Johnson										25a. REC'D BY REGISTRAR 8521 Loch Raven Blvd. 21204									
25b. REGISTRAR'S SIGNATURE Charles Judge										DATE DEC 30 1968									

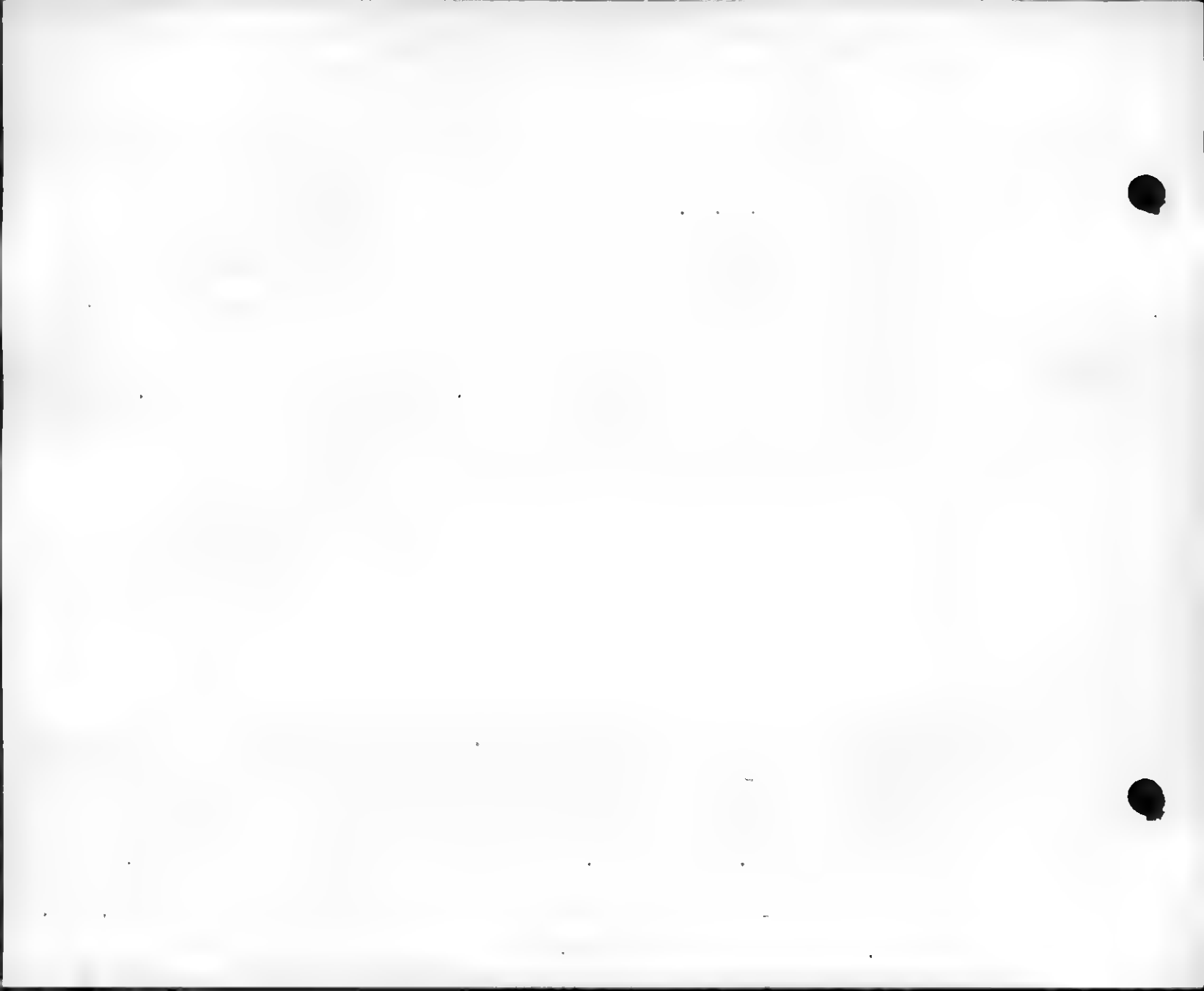


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
304 REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
17029 CERTIFICATE OF DEATH 17039											
1. DECEASED-NAME (Type or print)			First NINA			Middle V			Last FORD		
3. SEX F			4. RACE W			5. DATE OF BIRTH FEBRUARY 26, 1884			2a. DATE OF DEATH Month 9 Day 1968		
7a. BIRTHPLACE (State or foreign country) CONNECTICUT			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE		
10. CITY OR TOWN OF DEATH CATONSVILLE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SHADY NOOK NURSING HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE			13c. CITY OR TOWN HALETHORPE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First Middle Last WILLIAM H. VAN KEURON			15. MOTHER'S MAIDEN NAME First Middle Last MINNIE GIBBS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO 027-09-1385		
17. INFORMANT Address RUTH F. WHEELER 1717 FAIRVIEW AVE. 21227			17. INFORMANT Address RUTH F. WHEELER 1717 FAIRVIEW AVE. 21227			17. INFORMANT Address RUTH F. WHEELER 1717 FAIRVIEW AVE. 21227			17. INFORMANT Address RUTH F. WHEELER 1717 FAIRVIEW AVE. 21227		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months +											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 10</u> , 19 <u>68</u> , to <u>Dec. 9</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec. 9</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>John A. Nesbitt, Jr.</u>			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 12-10-68		
22d. PHYSICIAN'S NAME (Type) Dr. John A. Nesbitt, Jr.			22e. ADDRESS 1009 Frederick Road, Balto. Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12-12-68			23c. NAME OF CEMETERY OR CREMATORY Crest Lawn Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore City Balto. Md.		
24. FUNERAL DIRECTOR Howard H. Hubbard 4107 Wilkens Ave. 21229			25a. REC'D BY REGISTRAR DATE DEC 13 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



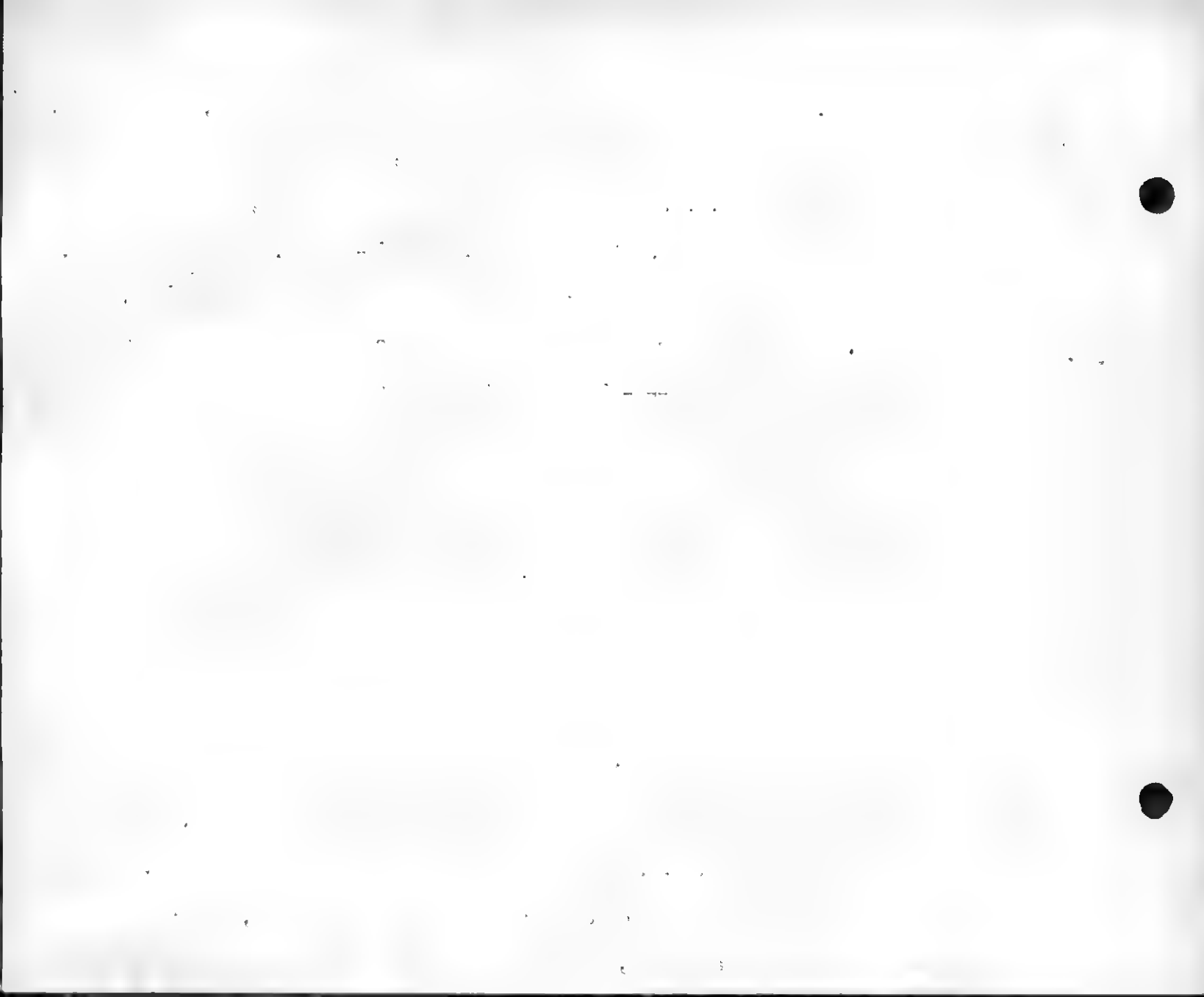
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 1 yrs after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with in 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17040

1 DECEASED NAME (Type or print) First Middle Last W. ROBERT FRANK		2a. DATE OF DEATH Month Day Year DECEMBER 21, 1968		2b. HOUR 11:59 PM
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH FEBRUARY 21, 1913	6 AGE (in years lost birthday) 55 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH BALTIMORE, Md	
10 CITY OR TOWN OF DEATH TOWSON	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during last 12 months, if ever if retired) Major - BALTO. CITY POLICE DEPT.	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Northhill Rd 979 Northhill Rd. #21218
14 FATHER'S NAME First Middle Last E. Ross Franck		15. MOTHER'S MAIDEN NAME First Middle Last Alice V McLaughlin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 213-01-6355	17 INFORMANT Address Mrs Anna H Franck Same	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Thrombotic Occlusion of Right Circumflex Branch</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Compensative Heart Failure</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Compensative heart failure</u>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or RFD No	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>December 21, 1968</u> , to <u>December 22, 1968</u> , that (I) (we) last saw the deceased alive on <u>December 21, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d.d) (did not) view the body after death.				
22b. SIGNATURE <u>T. Cilliani</u>		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED December 22, 1968	
22d. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D.		22e. ADDRESS 7620 York Road Baltimore, Md. 21204		
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE 12/26/68	23c. NAME OF CEMETERY OR CREMATORY Loudon Park	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR ADDRESS Leonard J Ruck Inc Baltimore, Maryland		25a. RECEIVED BY REGISTRAR DATE DEC 26 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE HEALTH DEPT

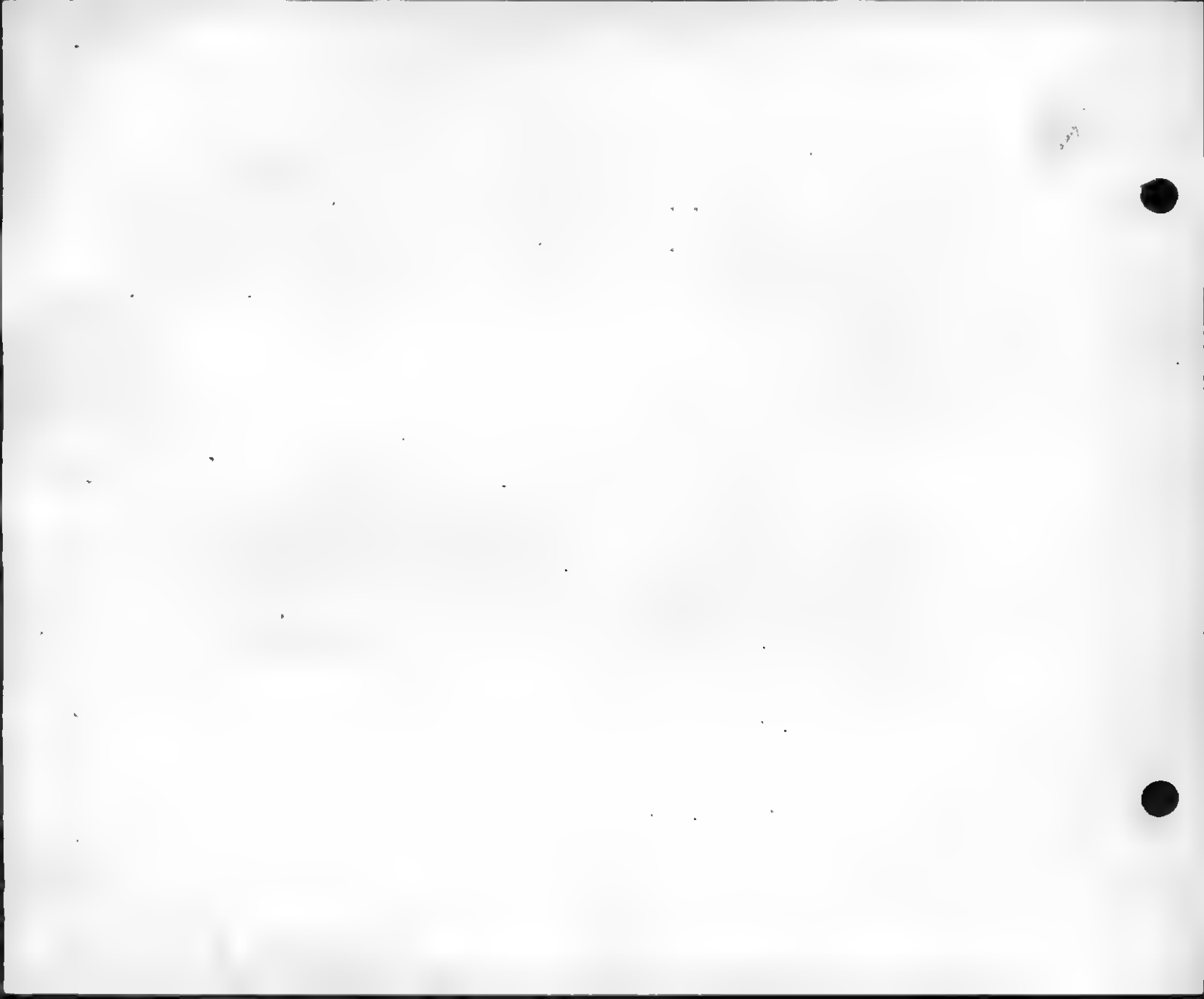
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 13 Film 3108
1/5/69 kk
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
17031 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17041

1 DECEASED NAME (Type or Print) Elizabeth			First Middle Last Freitag			2a DATE KNOWN OF DEATH MATED December 22 1968			2b HOUR 6.25 PM		
3 SEX Female	4 RACE White	5. DATE OF BIRTH 10-2-84	6 AGE (In years last birthday) 84 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD December 22 1968		2d HOUR M	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore					
10 CITY OR TOWN OF DEATH Towson			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			2a USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE Maryland			13b COUNTY Baltimore			13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 6308 Belair Rd. 5000 BELAIR AVE. LEAPAR	
14 FATHER'S NAME Julius			First Middle Last Franz			15 MOTHER'S MAIDEN NAME Christina			First Middle Last Barth		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b SOCIAL SECURITY NO (If yes give war or dates of service) 216-46-2457			17. INFORMANT ADDRESS Mrs. Helen Fak, 5916 Breckenridge Road					
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Congestive Failure IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of Left Hip DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS 3 WEEKS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Generalized Arteriosclerosis											
19a DATE OF OPERATION 12/21/68			19b CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture of Left Hip			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year 3 P.M. December 21 1968			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 for Part 2, Item 1B) Fall in Room					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Nursing Home			21f LOCATION Street or R.F.D. No City or Town Bellona Avenue Baltimore 21212					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles F. O'Donnell			EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			22b DATE SIGNED 12/27/68		
23a BURIAL CREMATION, REMOVAL (Specify) Burial			23b DATE 12/26/68			23c NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d LOCATION (City or town) (County) (State) Baltimore, Md.		
24 FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home 4210 Belair Road.						25a REC'D BY REGISTRAR DEC 26 1968			25b REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health or to burial, cremation, or removal, and in any event, within 72 hours after death.

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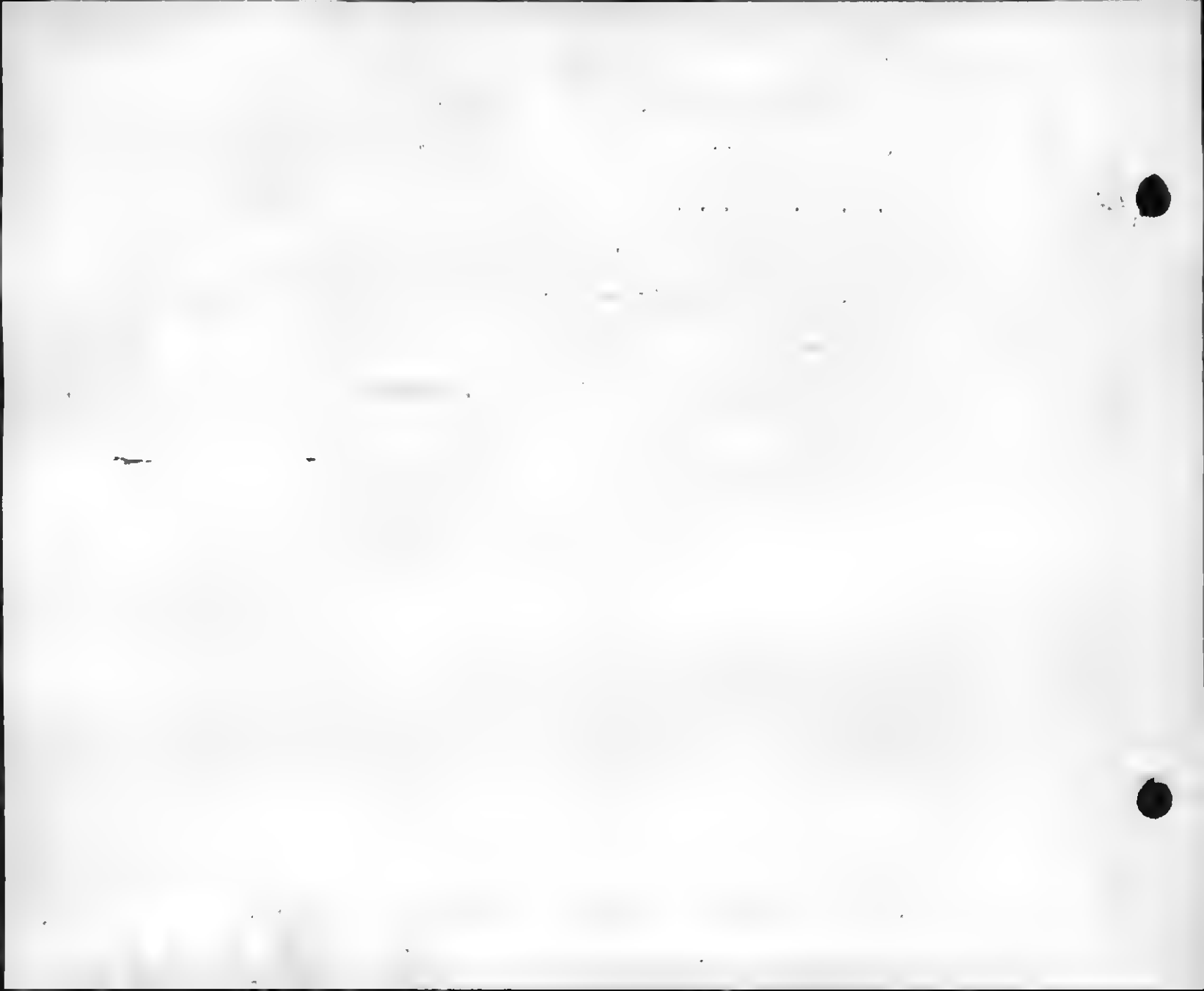
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17032

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17042

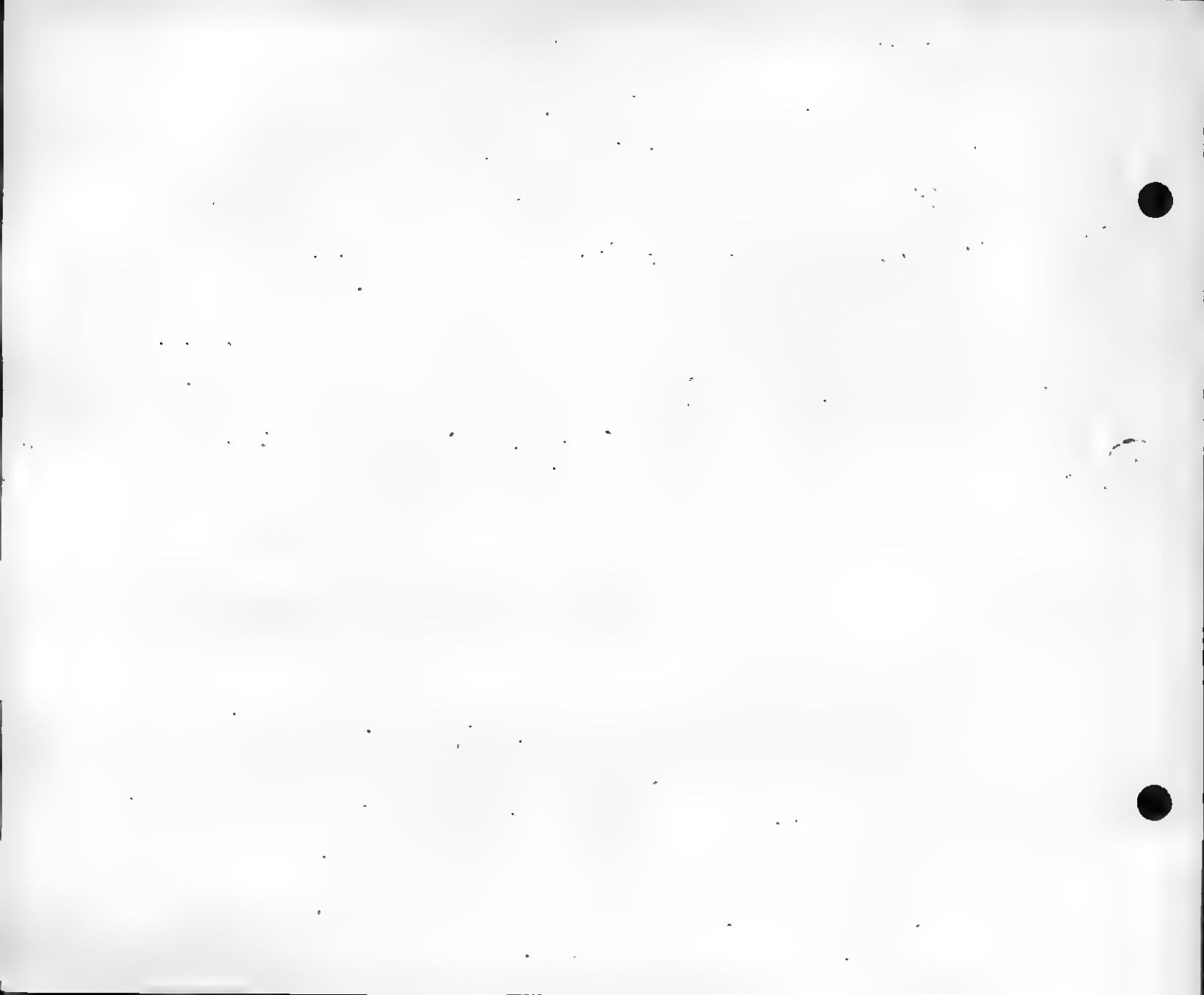
1 DECEASED-NAME (Type or print)		First Kathryn	Middle M.	Last French	2a. DATE OF DEATH Month 12 Day 20 Year 1968		2b. HOUR M
3 SEX Female		4 RACE White		5 DATE OF BIRTH May 31, 1878		6 AGE (In years last birthday) 90 YRS	
7a. BIRTHPLACE (State or foreign country) Balto. CO. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md	
10 CITY OR TOWN OF DEATH Parkville		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 8710 Wendell Ave		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) never worked		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME First Andrew		Middle French		Last Margaret		15 MOTHER'S MAIDEN NAME First Margaret	
Middle Swope		Last Swope		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO 219 50 9708T		17 INFORMANT Address Mrs. Thomas F. Bufter 6523 Loch Hill Rd.					
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 485X Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Adelto Corcoran heart							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Sept 3 , 1968, to Dec 19 , 1968, that (I) (we) last saw the deceased alive on Dec 19 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Sebastian Russo		DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED Dec 20 1968	
22d. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO MD		22e. ADDRESS 5017 Harford Rd Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/23/1968		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24 FUNERAL DIRECTOR Mitchell Wiedefeld Home 6500 York Rd.				25a. REC'D BY REGISTRAR DEC 27 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) LESTER			First J Middle FRIEDMAN Last			2a DATE OF DEATH Month 12 Day 11 Year 68			2b. HOUR 11:25 AM		
3 SEX MALE			4. RACE White			5 DATE OF BIRTH 12-19-94			6 AGE (In years last birthday) 73 YRS.		
7a. BIRTHPLACE (State or foreign country) Ohio			7b. CITIZEN OF WHAT COUNTRY? U.S.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE Md		
10 CITY OR TOWN OF DEATH Towson Md			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CHESAPEAKE MANOR 159 HOME ST. E. JEFFERSON			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Engineer Naval			12b. KIND OF BUSINESS OR INDUSTRY Automatrical		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md			13b. CITY OR TOWN Edgewater			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER Box 319-D		
14. FATHER'S NAME First FRANK Middle FRIEDMAN Last			15. MOTHER'S MAIDEN NAME First Linda Middle Bachmann Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 220-44-2396			17 INFORMANT Genera. White Address Bowie, Md					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Posterior 171.7 DUE TO, OR AS A CONSEQUENCE OF 1/3 OF tongue Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 17											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12/4/68 to 12/11/68 , that (I) (we) last saw the deceased alive on 12/11/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles F. Donald						22c. DATE SIGNED 12/11/68					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS 7501 York Rd - Towson 21207					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE Dec 16, 1968			23c. NAME OF CEMETERY OR CREMATORY Spring Grove Cemetery			23d. LOCATION (City or Town) (County) (State) Cincinnati Hamilton Ohio		
24. FUNERAL DIRECTOR P. Gash's Sons ADDRESS Hyattsville, Md.						25a. REC'D BY REGISTRAR DATE DEC 16 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

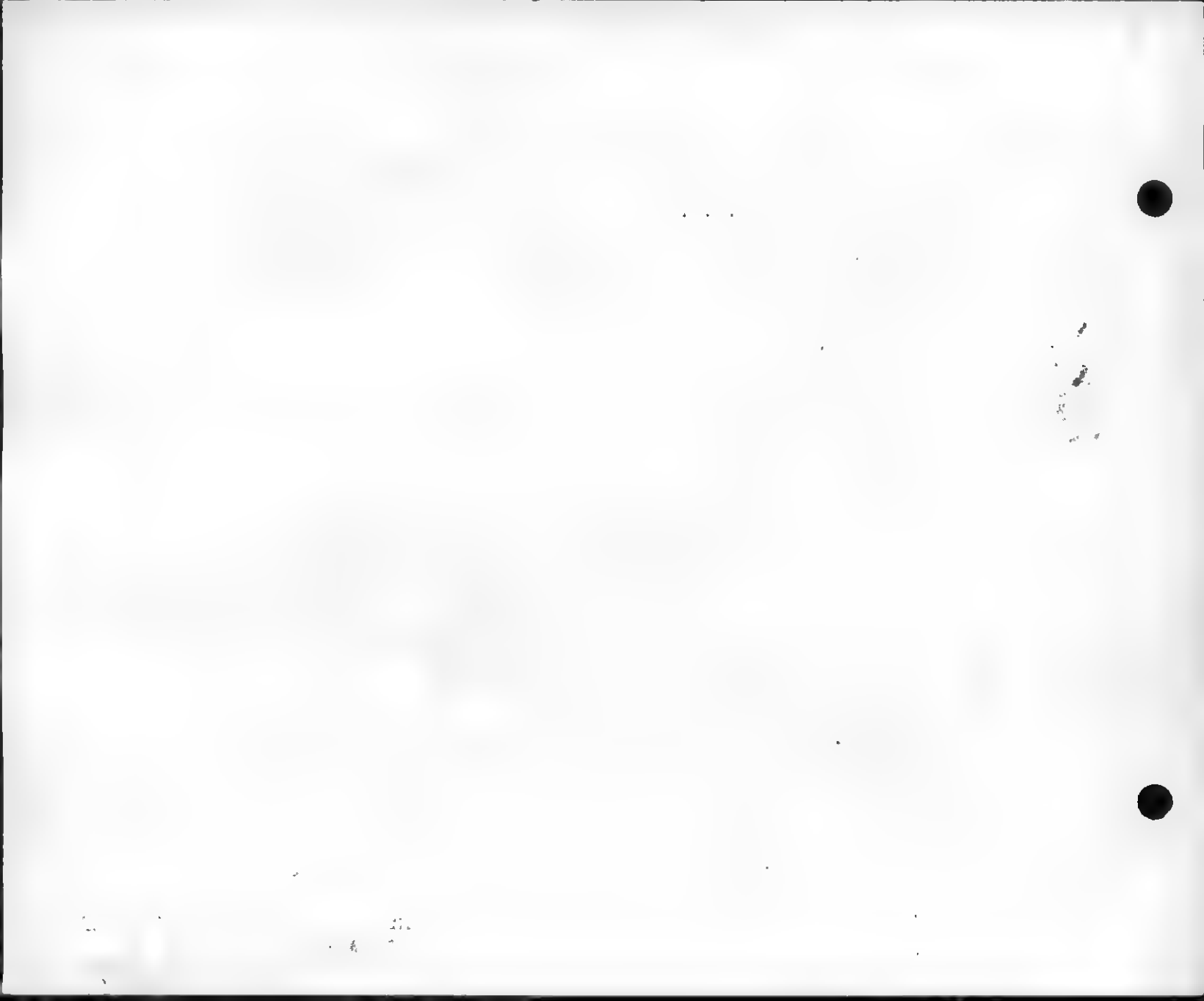


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal and in any event, within 72 hours of death.

VR A15 4
45M 1

<div style="display: flex; justify-content: space-between;"> 17034 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17044 </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>																
1 DECEASED NAME (Type or print)			First IRVIN			Middle MELVIN			Last FROCK			2a DATE OF DEATH Month DECEMBER Day 7 Year 1968			2b. HOUR 2:25 PM	
3 SEX MALE			4. RACE CAUCASIAN			5 DATE OF BIRTH APRIL 20, 1900			6 AGE (In years lost birthday) 68 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) MARYLAND			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE			Md				
10 CITY OR TOWN OF DEATH FORT HOWARD			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMINISTRATION HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) SECURITY GUARD			12b KIND OF BUSINESS OR INDUSTRY							
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b COUNTY BALTIMORE			13c CITY OR TOWN BALTIMORE			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 3831 LYNDALE AVENUE				
14. FATHER'S NAME			First STEPHEN			Middle FROCK			Last ANNIE			15. MOTHER'S MAIDEN NAME First ANNIE Middle SWEN Last SWEN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) YES WW I			16b SOCIAL SECURITY NO 213 05 7791			17 INFORMANT CLINICAL RECORDS, VA HOSPITAL, FT HOWARD, MD						Address				
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EMBOLUS															MINUTES	
200d Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) MALIGNANT LYMPHOMA															?	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 2002																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that HE (this hospital) attended the deceased from 10/30/68 , 19____, to 12/7/68 , 19____, that HE (we) last saw the deceased alive on 12/7/68 , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. DO NOT view the body after death.																
22b. SIGNATURE Neilson Neilson			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED 12 7 68							
22d. PHYSICIAN'S NAME (Type) NEILSON NEILSON, M.D.			22e. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND													
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 12/11/68			23c. NAME OF CEMETERY OR CREMATORY BALTO NATIONAL CEMETERY			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND							
24. FUNERAL DIRECTOR ULLIRICH FUNERAL HOME, 4210 BELAIR RD, BALTO, MD			ADDRESS			25a. REC'D BY REGISTRAR DEC 11 1968			25b. REGISTRAR'S SIGNATURE Charles Judge							



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 8 Film 108

1/8/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17045

1 DECEASED NAME (Type or Print) GROVER EUGENE FUNKHOUSER			2a. DATE KNOWN OF ESTABLISHED DEATH <input checked="" type="checkbox"/> Month 12 Day 25 Year 1968			2b. HOURS M
3 SEX Male	4. RACE White	5. DATE OF BIRTH 11/27/28	6. AGE (In years last birthday) 40 YRS	IF UNDER 1 YEAR MONTHS _____ DAYS _____	IF UNDER 24 HRS HOURS _____ MIN. _____	2c. DATE PRONOUNCED DEAD Month December Day 25 Year 1968
7a. BIRTHPLACE (State or foreign country) MOREFIELD, W. VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, OR INSTITUTION (if not in hospital give street address) Baltimore County General Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SERGEANT		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY HOWARD		13c. CITY OR TOWN Ellicott City	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 108 Old Frederick Rd.
14. FATHER'S NAME LLOYD FUNKHOUSER			15. MOTHER'S MAIDEN NAME EUNICE HOSE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. KOREAN 216-24-1551		17. INFORMANT MRS. RALPH FUNKHOUSER		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia by piece of meat DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 12-25 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Choked on piece of meat		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) apartment		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____ 240 Oella Ave.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Charles S. Springate		EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED December 26, 1968
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12-28-68		23c. NAME OF CEMETERY OR CREMATORY OLIVET		23d. LOCATION (City or Town) (County) (State) MOREFIELD, W. VA
24. FUNERAL DIRECTOR HIGDON & SONS		ADDRESS 5140 ELLICOTT CITY, MD		25a. REC'D BY REGISTRAR DEC 31 1968		25b. REGISTRAR'S SIGNATURE Charles Judge



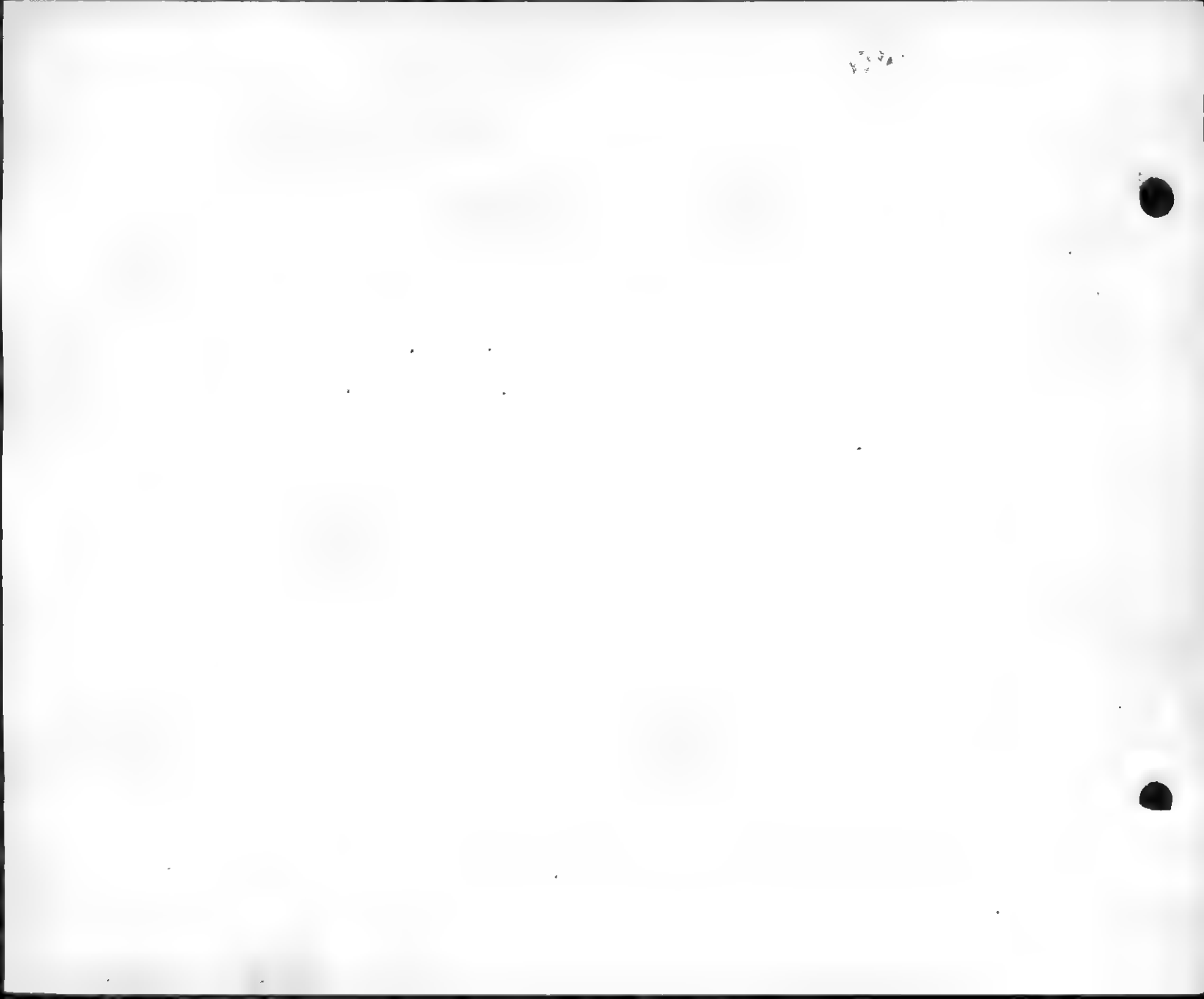
TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15
45M - 1-68

<div style="display: flex; justify-content: space-between;"> 1-036 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17046 </div> <div style="text-align: center; font-weight: bold;">CERTIFICATE OF DEATH</div>												
1 DECEASED NAME (Type or print) First Middle Last GERALD THOMAS FURNESS						2a DATE OF DEATH Month Day Year December 25 1968			2b HOUR 1:45 PM			
3 SEX Male		4 RACE White		5 DATE OF BIRTH 9-16-05			6 AGE (In years last birthday) 63 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Vermont		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.						
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) St. Joseph Hospital				12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Hartford Steam Boiler Company			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b COUNTY No		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1028 Woodson Rd. #21212				
14 FATHER'S NAME First Middle Last Moses J. Furness						15 MOTHER'S MAIDEN NAME First Middle Last Winifred Fitzgerald						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) WW II				16b SOC. SEC. NO.		17 INFORMANT Wife - Mabel S. Address Same						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral Hemorrhage</u> <u>4319</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or RFD No.		City or Town		County State		
22a I certify that (I) (this hospital) attended the deceased from <u>12-22</u> , 19 <u>68</u> , to <u>12-25</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-25-68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death												
22b SIGNATURE 		22c DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22e DATE SIGNED 12-25-68						
22d. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.		22e ADDRESS 7620 York Road, Towson, Md. 21204										
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 12/30/68		23c NAME OF CEMETERY OR CREMATORY Baltimore Nat. Cem.		23d LOCATION (City or Town) Balto Co		(County)		(State)		
24 FUNERAL DIRECTOR J. Heumann		24b ADDRESS 6067 Hartford Rd				25a REC'D BY REGISTRAR JAN 2 1969		25b REGISTRAR'S SIGNATURE Charles Judge				

MEDICAL CERTIFICATION



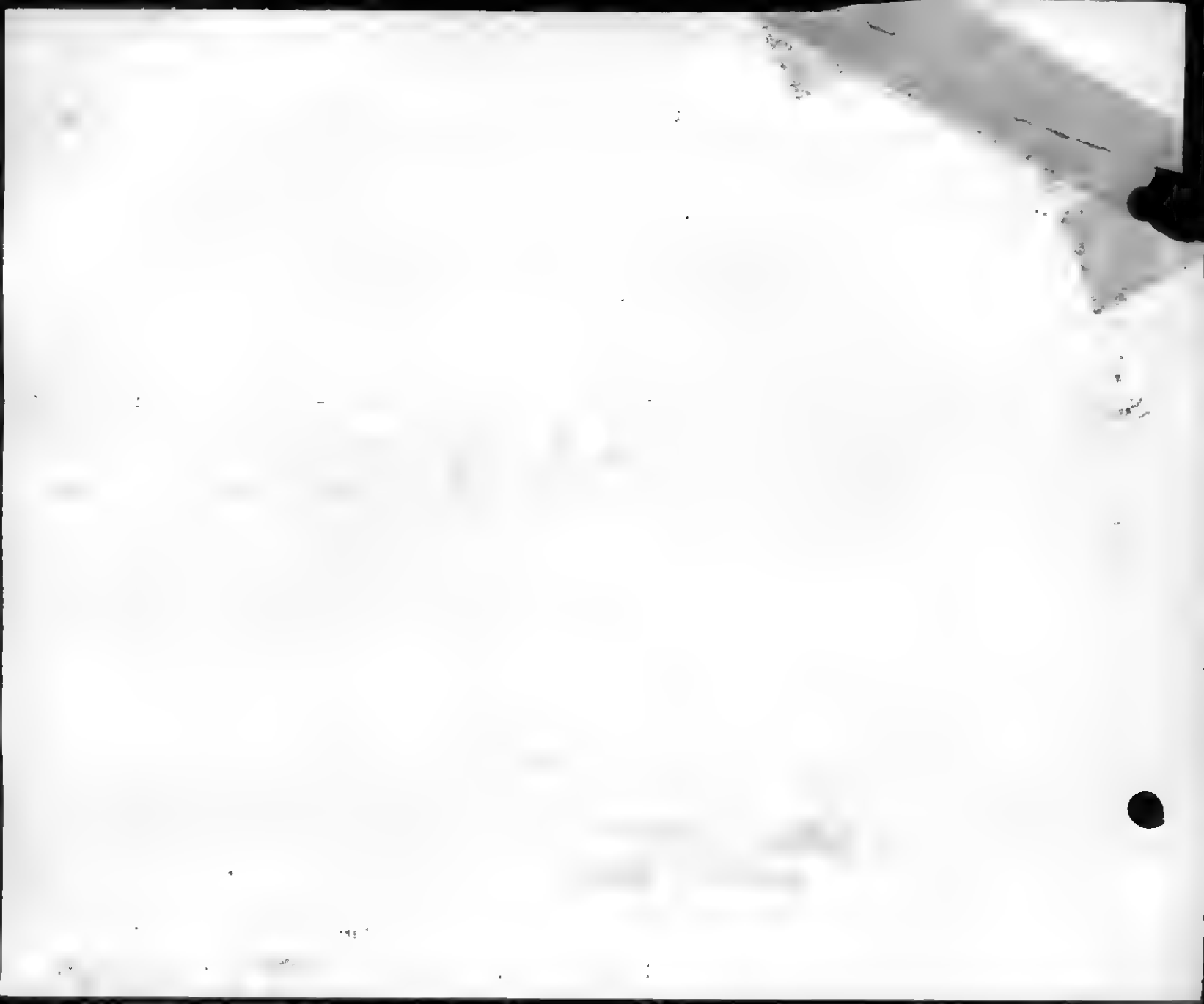
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17047

1 DECEASED-NAME (Type or print) Hill		2a DATE OF DEATH Month 12 Day 9 Year 68		2b HOUR 11:50 AM
3 SEX female	4 RACE white	5 DATE OF BIRTH 7/13/35	6 AGE (in years lost birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Md.	7b CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Baltimore	
10 CITY OR TOWN OF DEATH Randallstown	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore County Gen.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Seamstress	12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased admission) STATE Maryland	13b COUNTY Balto.	13c CITY OR TOWN Balto	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 361 Cedar Drive
14. FATHER'S NAME First Middle Last uk Claudius Hill		15. MOTHER'S MAIDEN NAME First Middle Last uk Unknown		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO		16b SOCIAL SECURITY NO 215-16-0770	17 INFORMANT hospital record Address Carl Von Lossberg-3612 Cedar Drive 21207	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial Infarction 4/10/7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201				
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No City or Town County State		
22a I certify that (I) (this hospital) attended the deceased from 12-9 , 19 68 to 12-9 , 19 68 , that (I) (we) last saw the deceased alive on 12-9 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death				
22b. SIGNATURE James J. DePue		DEGREE	ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED 12-9-68
22d. PHYSICIAN'S NAME (Type) PAGECITA TOPHUS		22e. ADDRESS BL2H		
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE 12-11-68	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24 FUNERAL DIRECTOR ADDRESS Ellsworth Armacost-4600 Liberty Hghts. Aven		25a REC'D BY REGISTRAR DEC 11 1968	25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.
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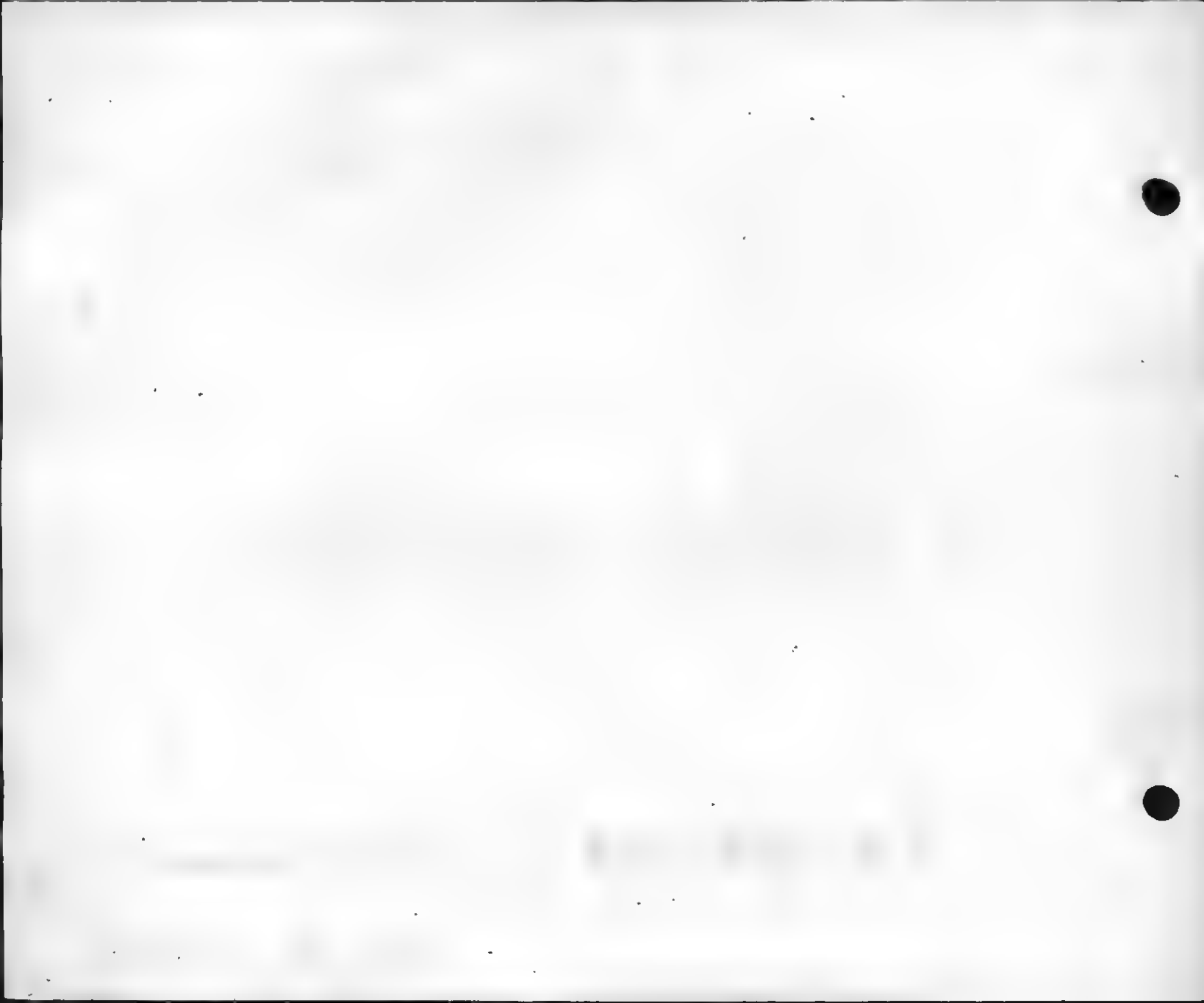


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or Print) First <u>HELEN</u> Middle <u>GARCIA</u> Last						2a DATE KNOWN OF DEATH <input type="checkbox"/> Month <u>DEC</u> Day <u>25</u> Year <u>1968</u>			2b HOUR <u>4</u> M <u>PM</u>			
3 SEX <u>F.</u>		4 RACE <u>W.</u>		5 DATE OF BIRTH <u>AUG. 5 1905</u>		6 AGE (In years last birthday) <u>63</u> YRS		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS HOURS <u></u> MIN <u></u>		
7a BIRTHPLACE (State or foreign country) <u>MD.</u>				7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>BALTIMORE</u>			2c DATE PRONOUNCED DEAD Month <u>DEC</u> Day <u>25</u> Year <u>1968</u>	
10 CITY OR TOWN OF DEATH <u>SENECA PARK</u>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>558 SENECA PK. RD</u>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			12b KIND OF BUSINESS OR INDUSTRY <u></u>	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD.</u> COUNTY <u></u>						13b CITY OR TOWN <u>BALTIMORE</u>		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <u>2328 FLEET ST.</u>		
14 FATHER'S NAME First <u></u> Middle <u></u> Last <u>MICHALSKI</u>						15. MOTHER'S MAIDEN NAME First <u></u> Middle <u></u> Last <u>?</u>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16b SOCIA. SECURITY NO <u>220-03-8476</u>		17 INFORMANT <u>MRS. ANNA BROWN</u>			ADDRESS <u>558 SENECA PK RD.</u>			
18 CAUSE OF DEATH (Enter only one cause per Part 1. Death was caused by IMMEDIATE CAUSE (a) <u>A-S-C-V-DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u></u>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4127</u>												
19a DATE OF OPERATION <u>4x41</u>				19b CONDITION FOR WHICH OPERATION WAS PERFORMED? <u></u>				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u></u>				21b TIME OF INJURY Month, Day, Year <u>19</u> HOUR A.M. <u></u> P.M. <u></u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u></u>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u></u>				21f. LOCATION Street or R.F.D. No <u></u> City or Town <u></u> County <u></u> State <u></u>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>M.B. Davis</u> EXAMINER'S NAME (Type) <u>MELVIN B DAVIS M.D.</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b DATE SIGNED <u>12/28/68</u>			
ADDRESS <u>2525 FLEET ST.</u>						ADDRESS (Street, city, town, or county) <u>6800 HORNINGTON RD. DUNDALK</u>						
23a BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE <u>DEC. 28, 1968</u>		23c NAME OF CEMETERY OR CREMATORY <u>ST. STANISLAUS CEM.</u>			23d LOCATION (City or Town) <u>BALTIMORE</u> (County) <u>MD</u> (State) <u>MD</u>					
24 FUNERAL DIRECTOR <u>RAYMOND L. KACZOROWSKI</u>						25a REC'D BY REGISTRAR <u>DEC 31 1968</u>			25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



**FOR STATE
HEALTH DEPT.**

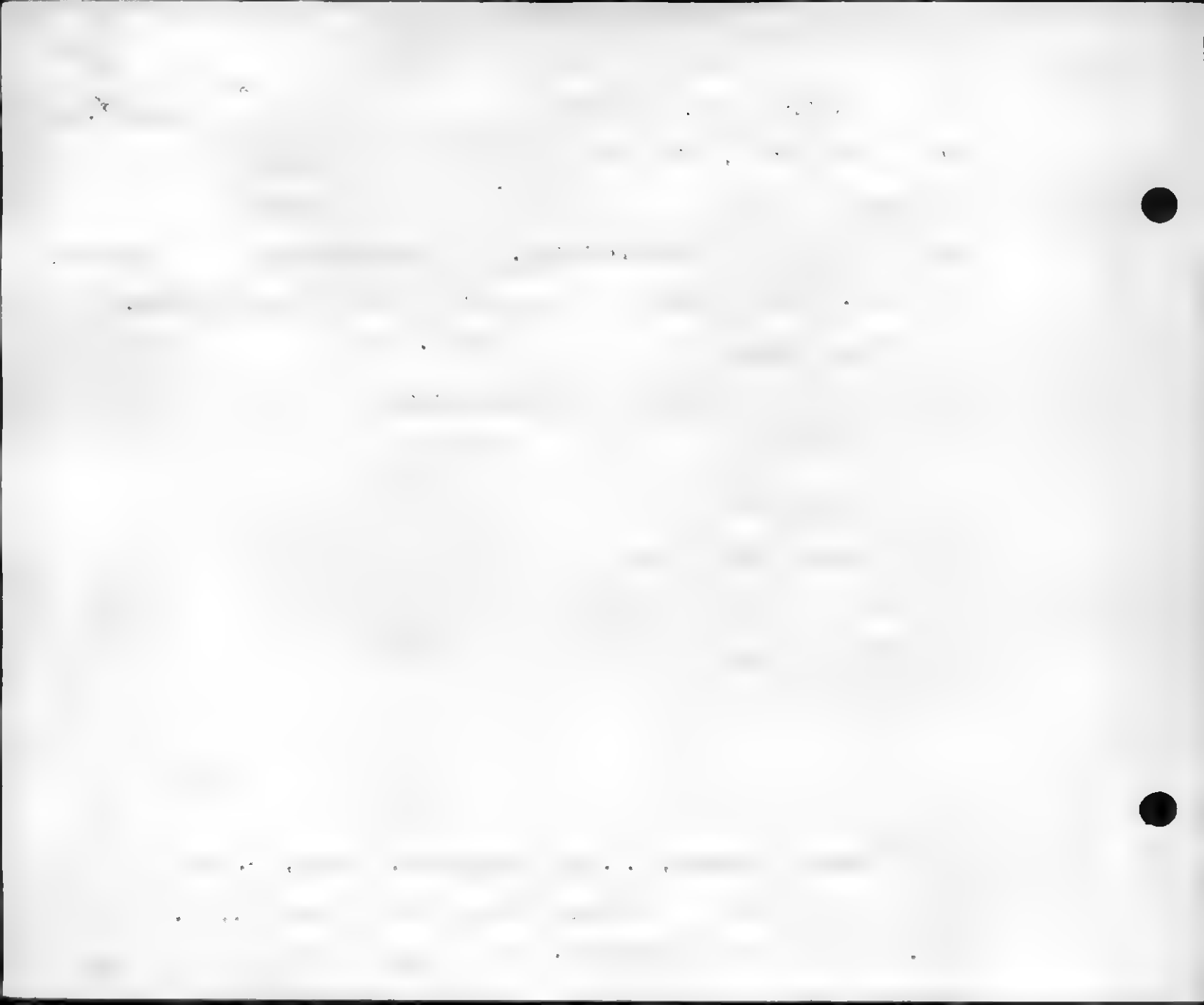
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17039

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17049

1. DECEASED-NAME (Type or Print) Oliver Wesley Garland			First Middle Last			2a. DATE KNOWN OF DEATH Month Day Year December 2, 1968			2b. HOUR 11:30 AM		
3 SEX Male	4 RACE CAU	5 DATE OF BIRTH Feb 2, 1908	6 AGE (In years last birthday) 60 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year December 3, 1968			2d. HOUR 1:30 PM
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Essex 21221			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 810 Arncliffe Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Grill Manager			12b. KIND OF BUSINESS OR INDUSTRY Restaurant		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Essex 21221		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 810 Arncliffe Rd.		
14. FATHER'S NAME George Garland			First Middle Last			15. MOTHER'S MAIDEN NAME Mary E. Davis			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 527 01 6332			17. INFORMANT Betty Garland			ADDRESS Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF HEVD (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 42											
19a. DATE OF OPERATION _____			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. _____ 19__			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) _____					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) _____			21f. LOCATION Street or R.F.D. No. _____			City or Town _____		County _____ State _____
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Theodore Patterson M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 12/4/68		
EXAMINER'S NAME (Type) Theodore Patterson, M.D. 3427 Dundalk Ave. Dundalk, Md. 21222						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPT. MEDICAL EXAMINER <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12/5/68			23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Pk.			23d. LOCATION (City or Town) (County) (State) Howard Co., Md.		
24. FUNERAL DIRECTOR James E. Bruzdinski 1407 Eastern Ave. 21221						25a. REC'D BY REG. STRAR DEC 6 1968			25b. REG. STRAR'S SIGNATURE Charles Judge		



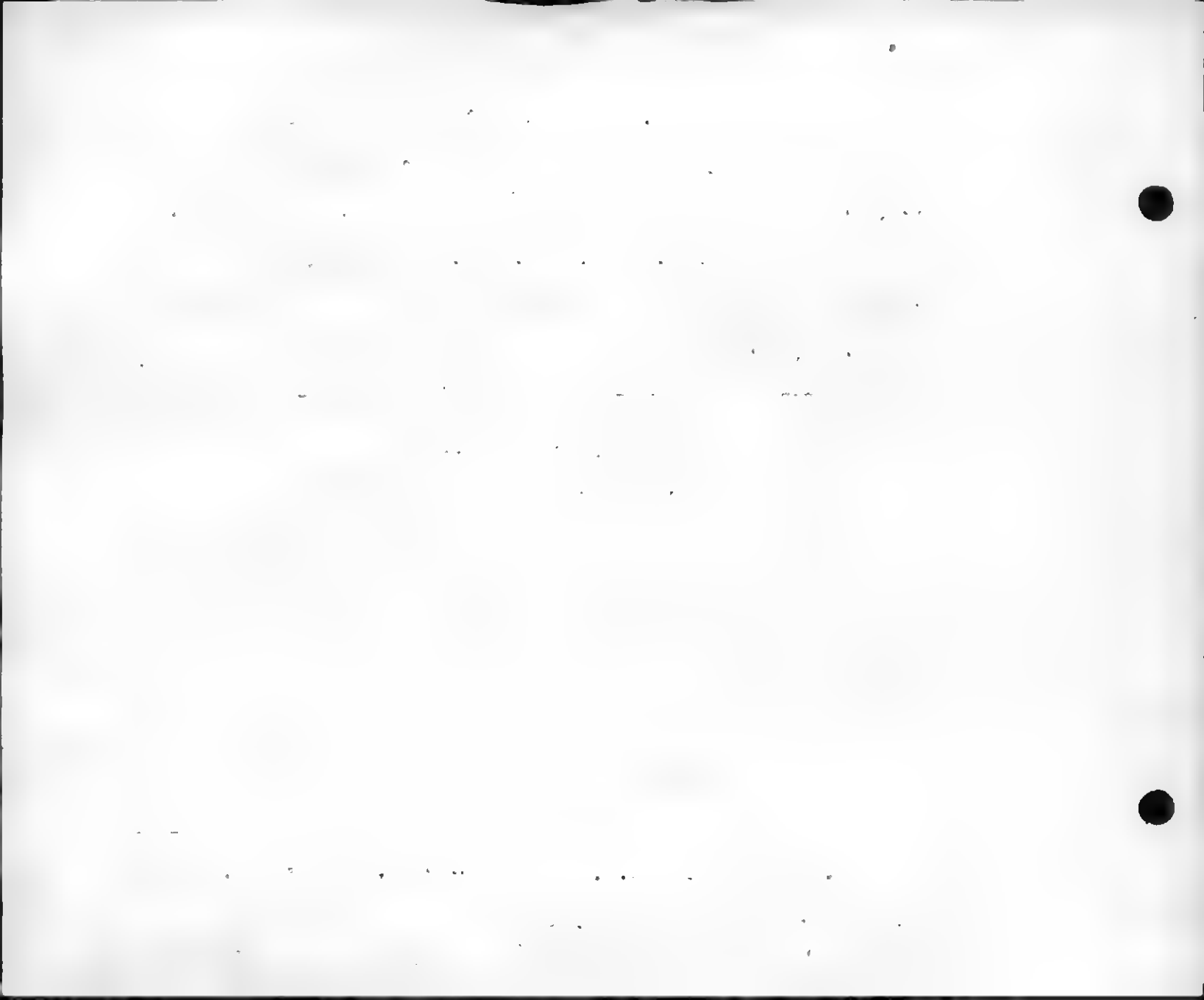
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-1
30M REV

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First Middle Last LESLIE A. GIBSON						2a. DATE OF DEATH Month Day Year 12 28 68			2b. HOUR 1:55 PM		
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH March 2nd, 1896			6. AGE (In years lost birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Co. Md.					
10. CITY OR TOWN OF DEATH TOWSON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREAT. BALT. MED. CEN.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Balto		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4 Upland Road		
14. FATHER'S NAME First Middle Last William A. Albaugh						15. MOTHER'S MAIDEN NAME First Middle Last Mary Hall Boblitz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no				16b. SOCIAL SECURITY NO 214-20-6304		17. INFORMANT Address Mr. David C. Gibson-4 Upland Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Failure 114X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Breast with Metastasis DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11-09 , 19 68 , to 12-28 , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 28 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE Chang-I Lin M.D.						22c. DATE SIGNED 12-28-68		22d. PHYSICIAN'S NAME (Type) Dr. Chang-I Lin M.D.			
22e. ADDRESS 6701 N. Charles St.		22f. ADDRESS 21204									
23a. BURIAL, CREMATION REMOVAL (Specify) Cremation		23b. DATE 12/30/68		23c. NAME OF CEMETERY OR CREMATORY Greenmount				23d. LOCATION (City or Town) (County) (State) Baltimore			
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home-6500 York Rd. 21212						25a. REC'D BY REGISTRAR JAN 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

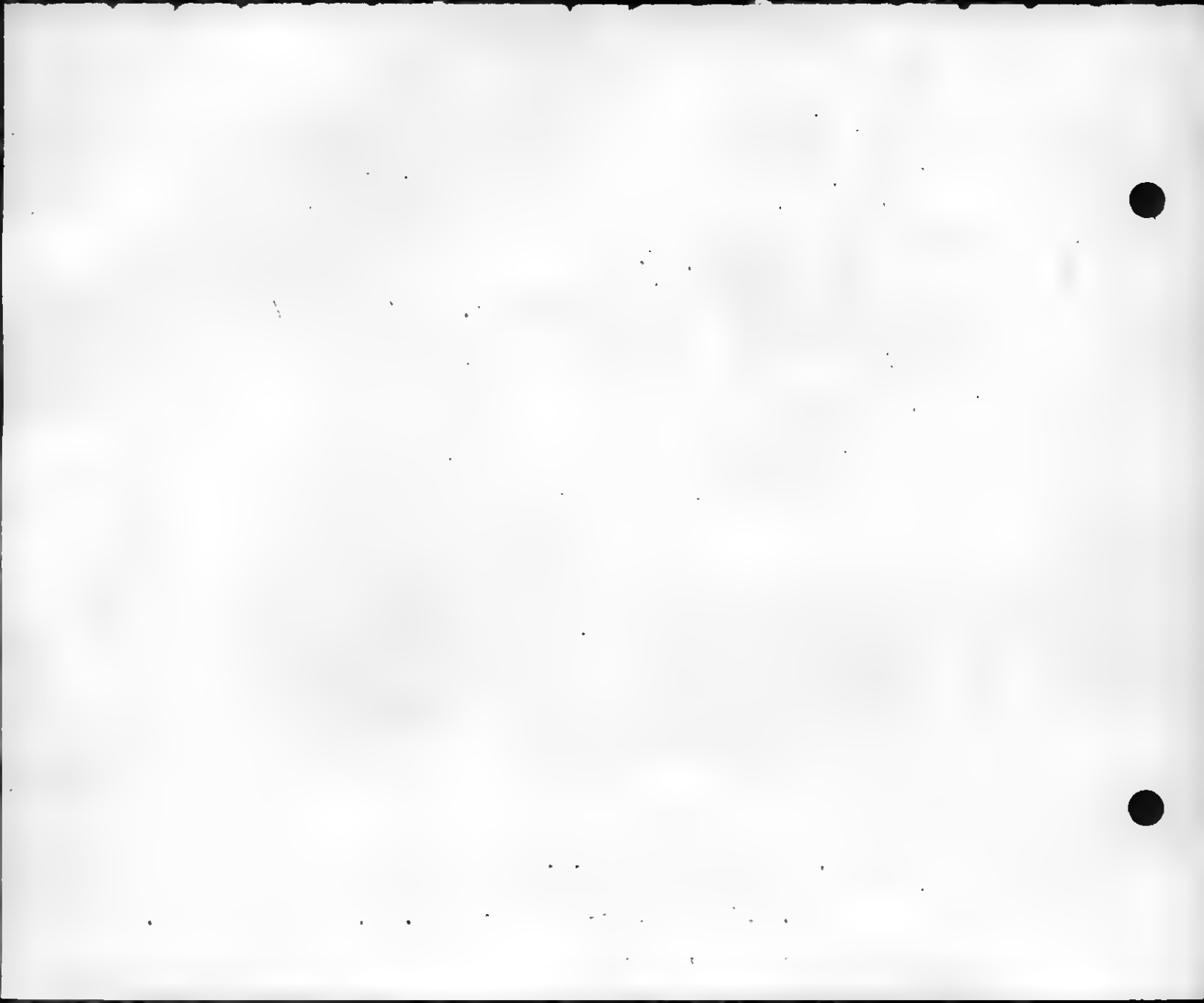


VR AIS (4)
20M 1/65

12013

17051

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. LENGTH OF STAY IN 1b <u>119 Glyndon Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>119 Glyndon Drive</u>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>	
f. STREET ADDRESS <u>119 Glyndon Drive</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Beulah P.</u> Middle <u>Gill</u> Last <u></u>		4. DATE OF DEATH Month <u>December</u> Day <u>5</u> Year <u>1968</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 11, 1898</u>
9. AGE (In years) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John L. Towney</u>		14. MOTHER'S MAIDEN NAME <u>Annie Carver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Family records</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma metastasis</u> DUE TO (b) <u>Gastric adenocarcinoma</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>151X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>4-16</u> , 19 <u>68</u> , to <u>12-14</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-14</u> , 19 <u>68</u> , and that death occurred at <u></u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Philip Bernstein</u>		22b. DATE SIGNED <u>12-6-68</u>	
22c. PHYSICIAN'S NAME (Type) <u>Philip Bernstein, M.D.</u>		22d. ADDRESS <u>112 Chartley Drive, Reisterstown, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 7, 1968</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Grace Falls Road Meth. Cem. Cockeysville, Md.</u>		23d. LOCATION (City, town or county) (State) <u></u>	
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>		25a. REC'D BY REGISTRAR <u>DEC 9 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

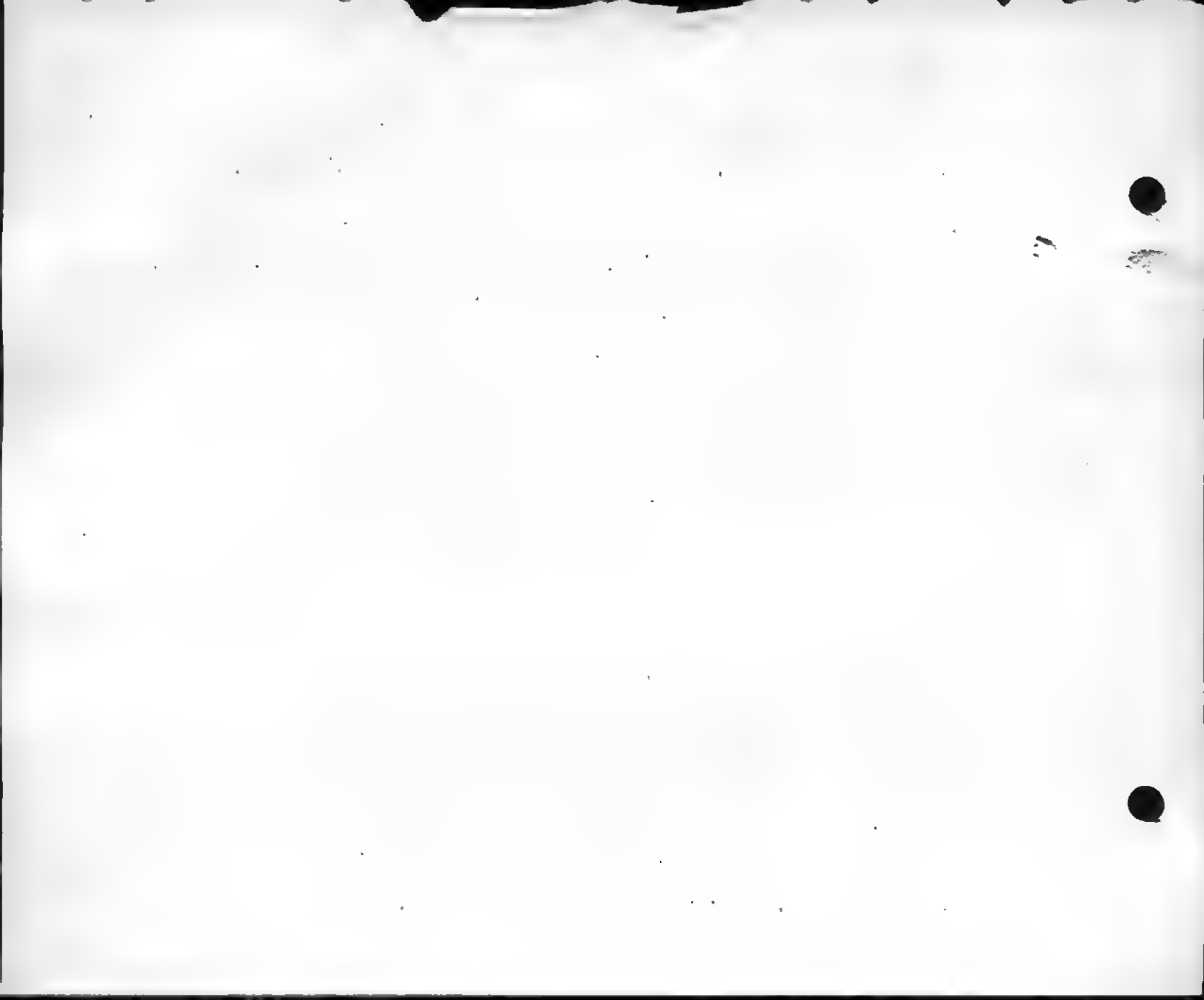


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17012 CERTIFICATE OF DEATH 17052

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Corbett (Monkton P.O.)</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Corbett Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Corbett (Monkton P.O.)</u> d. STREET ADDRESS <u>Corbett Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bessie Elizabeth Gillian</u> First Middle Last		4. DATE OF DEATH <u>December 11, 1968</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 5, 1884</u> 9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Family records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerosis, Cerebral Vascular Disease.</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension - Chronic Congestive failure</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 44			INTERVAL BETWEEN ONSET AND DEATH <u>3 yr.</u> <u>3 yr.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1963</u> to <u>Dec 11, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 11, 1968</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Herbert Mueller</u>		22b. DATE SIGNED <u>12/13/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>C HERBERT MUELLER JR</u>		22d. ADDRESS <u>PARKTON - Md - 21124</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 14, 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Monkton Methodist Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Monkton, Maryland</u>
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>		25a. REC'D BY REGISTRAR <u>DEC 16 1968</u> 25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17043

17053

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
JOSEPHINE			R. P.	GIZINSKI	DECEMBER Month 11 Day 1968 or		12:35A	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	7. UNDER 1 YEAR		8. UNDER 24 HRS
FEMALE	WHITE		JUNE 30, 1900		68 YRS	MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
POLAND	U.S.A.				BALTIMORE,			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INST. T.O.N. (If not a hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of last year, or even retired)		12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON		ST. JOSEPH HOSPITAL		HOMEMAKER				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	3a. INSIDE CITY, LIM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
MARYLAND				BALTIMORE		6616 BELFORD RD. #21206		
14. FATHER'S NAME		15. MOTHER'S M.A.D.E.N. NAME						
First Middle Last		First Middle Last						
Anthony Ruzskiewicz		Magdeline Klimas						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
No		217-01-7133A		Mr Stephen S Gizinski		Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)								
4157 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
(b) CONGESTIVE HEART FAILURE								
(c) DUE TO, OR AS A CONSEQUENCE OF HEPATOMA								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
4200								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town County State		
				Street or R.F.D. No				
22a. I certify that (I) (this hospital) attended the deceased from December 10, 1968 to December 11, 1968, that (I) (we) last saw the deceased alive on DECEMBER 11, 1968 and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death								
22b. SIGNATURE						22c. DATE SIGNED		
<i>Marciso Lobo</i>						DECEMBER 11, 1968		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
MARCISO LOBO, M.D.		7620 York Road		Towson, Md. #21204				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		12/14/68		Gardens Of Faith		Baltimore, Maryland		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Leonard J Ruck Inc Baltimore, Maryland				DATE DEC 11 1968		<i>Charles Judge</i>		



17014

CERTIFICATE OF DEATH

17054

1. DECEASED-NAME (Type or print) LAURA JESSIE GODDARD			2a. DATE OF DEATH Month 12 Day 17 Year 68			2b. HOUR 4:25 P.M.					
3. SEX F		4. RACE W		5. DATE OF BIRTH 12-11-10		6. AGE (In years last birthday) 58 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.			
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md					
10. CITY OR TOWN OF DEATH CATONSVILLE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY At Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE 2322 COUNTY BALTIMORE				13c. CITY OR TOWN WESTPARK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2322 Sydney Ave 21230			
14. FATHER'S NAME First unknown Middle unknown Last unknown				15. MOTHER'S MAIDEN NAME First Emma Middle May Last ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) -		16b. SOCIAL SECURITY NO 220-09-6315		17. INFORMANT Dr. Howard A. Zaleski				Address 2845 Rd. Hollins Ferry			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST. 4/1/1 DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIOSCLEROTIC HEART-DISEASE									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 42.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 12 Day 17 Year 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or RFD No 1 City or Town Woodlawn County MD. State MD.							
22a. I certify that (I) (the hospital) attended the deceased from 3-38, 1961 , to 12-17, 1968 , that (I) (we) last saw the deceased alive on 12-17, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Signature M.D.				DEGREE M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED 12-17-68			
22d. PHYSICIAN'S NAME (Type) EVELIO A. FELIPE M.D.				22e. ADDRESS SPRING GROVE STATE HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/20/68		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		23d. LOCATION (City or Town) (County) (State) Woodlawn Md.					
24. FUNERAL DIRECTOR John J. Cowan & Son Inc.				ADDRESS 301 W. Preston St. Baltimore, Md.				25a. REC'D BY REGISTRAR DEC 20 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3, and 4, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1515
REV 1-68

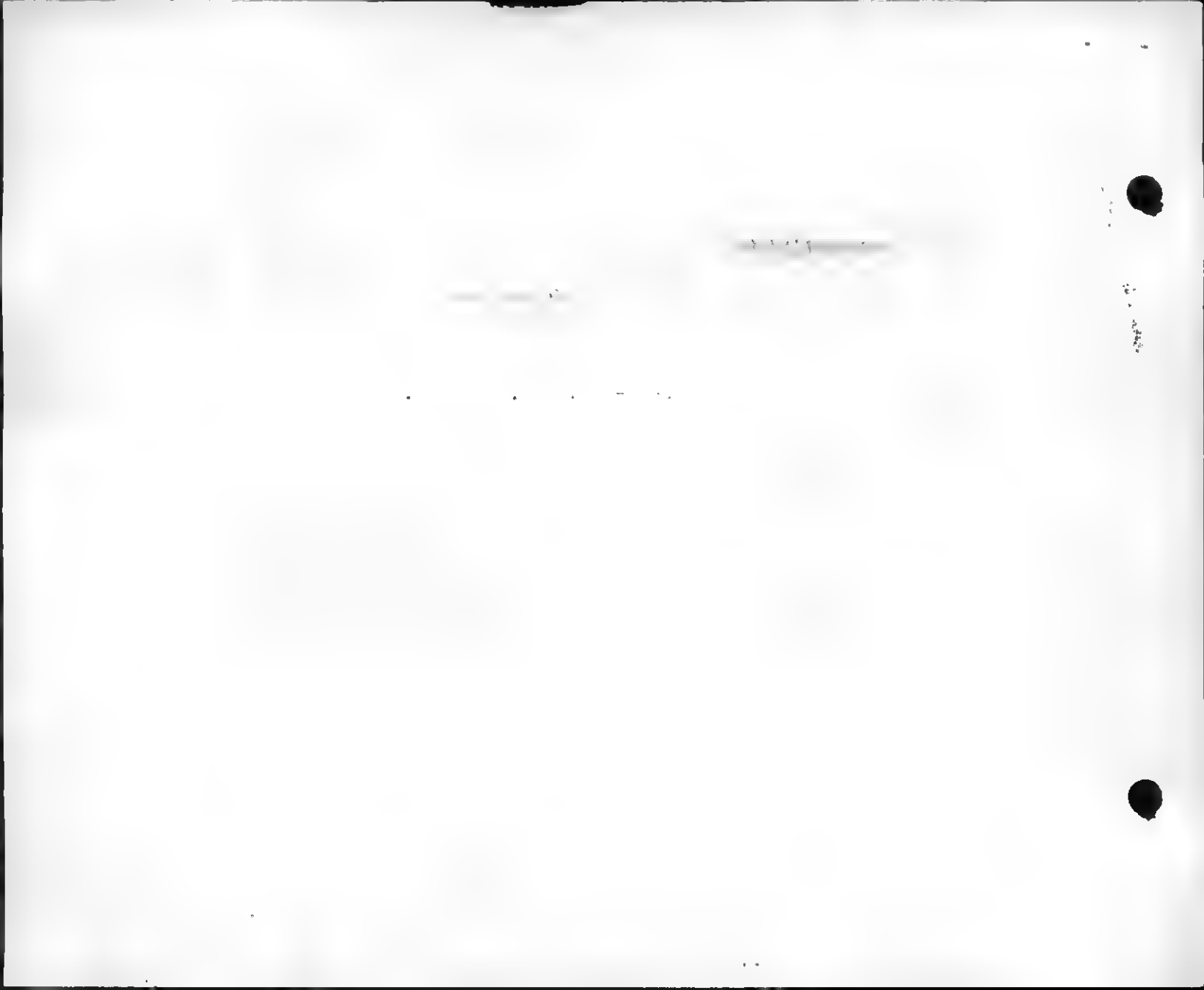
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17045

17055

1. DECEASED-NAME (Type or print) PAULA			First Middle Lost			2a. DATE OF DEATH Month DEC Day 9 Year 1968			2b. HOUR 9:30 MIN 58		
3. SEX Female			4. RACE White			5. DATE OF BIRTH 2/6/32			6. AGE (In years last birthday) 36 YRS.		
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore County Md.		
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6726 LONGHILL ROAD			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife			12b. KIND OF BUSINESS OR INDUSTRY AT HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIM 15? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER 6726 Longhill Rd.			14. FATHER'S NAME First MORRIS Middle GINSBURG Lost MARY			15. MOTHER'S MAIDEN NAME First MARY Middle SILVERMAN Lost ANNE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 213-28-9791			17. INFORMANT MR. HENRY H. GOLD			Address 6726 LONGHILL ROAD #21207		
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRA PERITONEAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (b) RUPTURED HEMORRHAGIC OVARIAN CYST DUE TO, OR AS A CONSEQUENCE OF (c) ANTICOAGULANT THERAPY									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 2											
9a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1950 to 12-9-1968 , that (I) (we) last saw the deceased alive on 12-9-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE L.F. Auer						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/9/68		
22d. PHYSICIAN'S NAME (Type) L.F. Auer						22e. ADDRESS UNIVERSITY HOSP.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 12-10-68			23c. NAME OF CEMETERY OR CREMATORY MIKRO KODESH-BETH ISRAEL			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD						25a. REC'D BY REGISTRAR DEC 10 1968			25b. REGISTRAR'S SIGNATURE J. Charles Judge		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17046

CERTIFICATE OF DEATH

17056

1. DECEASED NAME (Type or print)		First Samuel	Middle V	Last Goldberg	2a. DATE OF DEATH Month Day Year Dec 12 68		2b. HOUR 9 P. M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 2-22-02		6. AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto Md.		
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto County General Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) GROCERY STORE		12b. KIND OF BUSINESS OR INDUSTRY OWNER		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Balto		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9 Cobblestone Ct.
14. FATHER'S NAME First Middle Last Victor Goldberg		15. MOTHER'S MAIDEN NAME First Middle Last Bell not known		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown) (If yes give war or dates of service) NO				
16b. SOCIAL SECURITY NO 283-10-2354		17. INFORMANT Address MR. BERNARD KLEGER, 8808 ALLENSWOOD ROAD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 4:09 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) #201 Multiple Myeloma								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from Nov 22, 1967, to Dec 12, 1967, that (I) (we) last saw the deceased alive on Dec 12, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Bon Varasim		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 12/12/68		
22d. PHYSICIAN'S NAME (Type) BOON VARASIM		22e. ADDRESS Balto County General Hosp						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12-13-68		23c. NAME OF CEMETERY OR CREMATORY SHAAREI TFILOH		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				25a. REC'D BY REGISTRAR DATE DEC 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 111
30M REV 11-68

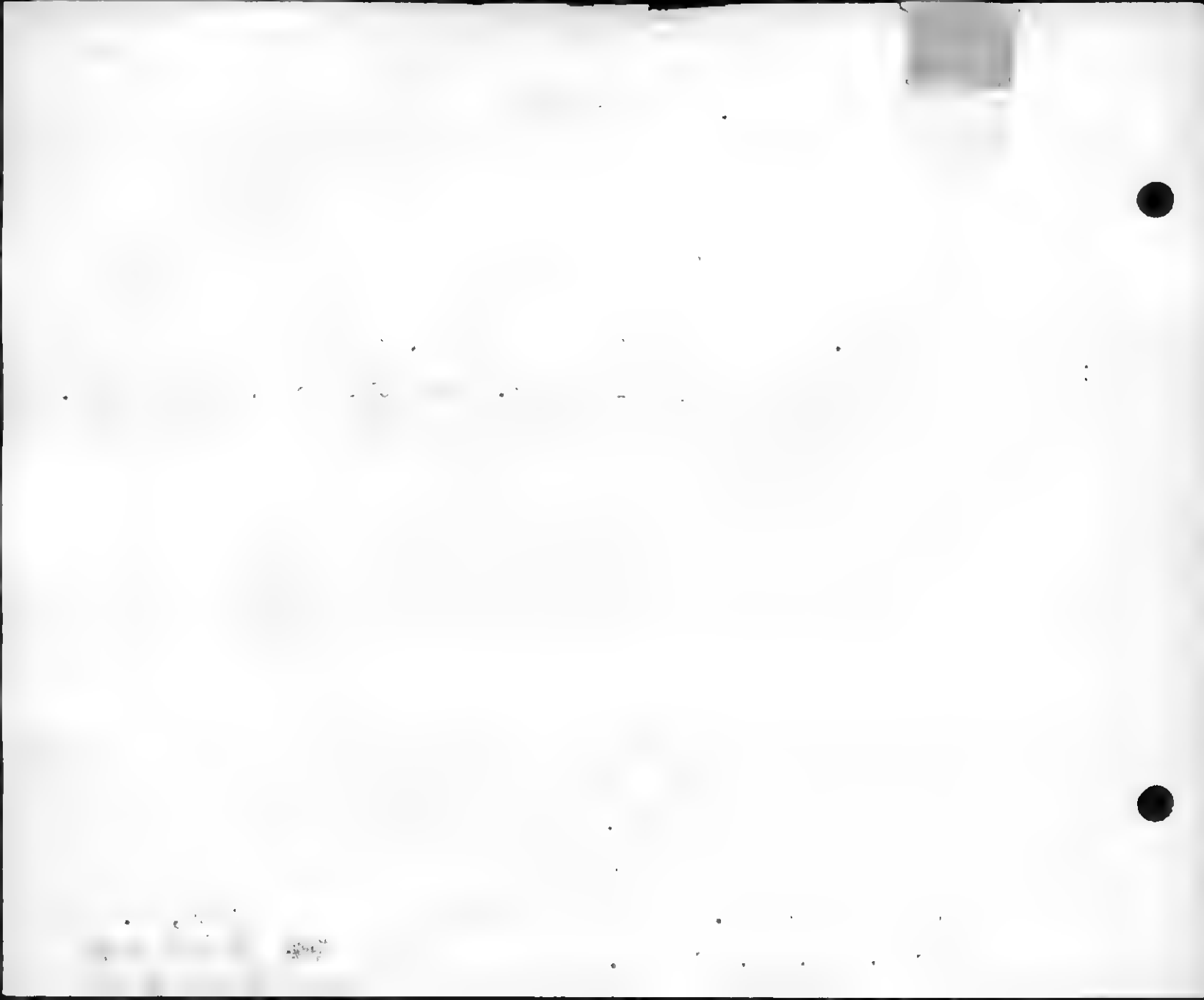
17047										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17057																																							
1. DECEASED-NAME (Type or print)										First Anna Middle R. Last Goldman										2a. DATE OF DEATH										2b. HOUR																													
																				12 Month 05 Day 08 Year										9:40																													
3 SEX Female										4. RACE White										5. DATE OF BIRTH 1-30-90										6. AGE (in years last birthday) 78 YRS.										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Russia										7b. CITIZEN OF WHAT COUNTRY? uk										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Baltimore Md.																													
10. CITY OR TOWN OF DEATH Randallstown										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore Co Gen Hosp										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) uk										12b. KIND OF BUSINESS OR INDUSTRY uk																													
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE: Md.										13b. COUNTY: Baltimore										13c. CITY OR TOWN: Balto										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER: 313 L. Garrison Ave.																			
14. FATHER'S NAME First n/a Middle Last										15. MOTHER'S MAIDEN NAME First n/a Middle Last																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) uk										(If yes give war or dates of serv.) uk										16b. SOCIAL SECURITY NO. uk										17. INFORMANT Address Mr. Harry Goldman 3513 Spaulding Ave																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))																														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4107										DUE TO, OR AS A CONSEQUENCE OF										Acute myocardial infarction																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b)										Cerebral artery disease										YEARS																													
										(c)										Arteriosclerotic cardiovascular disease										YEARS																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
19a. DATE OF OPERATION 4/20/1										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.										21f. LOCATION Street or RFD No City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 11-24-67, 19 67, to 12-5, 19 68, that (I) (we) last saw the deceased alive on 12-5-19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE Angelita Apiano										DEGREE										ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>										22c. DATE SIGNED 12-5-68																													
22d. PHYSICIAN'S NAME (Type) ANGELITA TO PACU																				22e. ADDRESS BC 94H																																							
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE 12/6/68										23c. NAME OF CEMETERY OR CREMATORY Han Sinai Benevolent										23d. LOCATION (City or Town) (County) (State) Rosedale Md																													
24. FUNERAL DIRECTOR Sylvan S. Leindson, Inc. 7010 Reisterstown Rd										ADDRESS										25a. REC'D BY REGISTRAR DATE DEC 5 1968										25b. REGISTRAR'S SIGNATURE																													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH		2b HOUR	
HESTER		E.		GOLDSBOROUGH		GOLDSBOROUGH		December 20 1968		8:45 PM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS	
Female		White		September 19, 1903		65 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Maryland		USA				Baltimore					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Towson		St. Joseph's Hospital		Homemaker							
13a USUAL RESIDENCE (Where deceased lived, if institution residence before date of death)		13b CITY OR TOWN		13c INSIDE CITY LIMITS?		13d STREET AND NUMBER					
Maryland		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7410 Old Harford Road					
14 FATHER'S NAME		15 MOTHER'S M A D E N NAME									
James H.		Agnes E. Henshaw									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		215-03-8172D		Mr. Samuel Goldsborough		1251 Winston Ave.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <u>Perforated gastric ulcer</u>											
31.1 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
5401											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. Month Day Year									
21d INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from <u>12-17</u> , 19 <u>68</u> , to <u>12-20</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>12-20-68</u> , 19 <u>68</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (do) (did not) view the body after death.											
22b SIGNATURE		22c DATE SIGNED									
<i>Samuel G. Lee</i>		12-21-68									
22d PHYSICIAN'S NAME (Type)		22e. ADDRESS									
Samuel G. H. Lee, M.D.		7620 York Rd. Towson 4, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		12/24/68.		Parkwood Cemetery		Baltimore, Md.					
24 FUNERAL DIRECTOR		ADDRESS		25a REG. BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
Leonard J. Ruck, Inc. Balto. Md. 21214				DEC 23 1968		<i>Charles J. Ruck</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17019

17059

1. DECEASED-NAME (Type or print) Robert F Goodell			2a. DATE OF DEATH Month 12 Day 25 Year 68			2b. HOUR 11:35 M		
3 SEX MALE		4 RACE white		5. DATE OF BIRTH 12/28/1986		6. AGE (In years last birthday) 81 YRS.		
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md		
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CHESAPEAKE MANOR NSG HOME 329 E TOWSON			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		
13a. USLA. RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE md.			13b. COUNTY BALTO.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5648 Woodmont Ave APT. A	
14. FATHER'S NAME First Middle Last Charles F. Goodell				15. MOTHER'S MAIDEN NAME First Middle Last Ada Graham				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 215 07 8869		17. INFORMANT Address Eleanor Goodell, 5648 Woodmont Ave. 21212				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 4369 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 2212								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year P M 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (1) (this hospital) attended the deceased from may , 19 66 , to DEC , 19 68 , that (1) (we) last saw the deceased alive on 12/24/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (and not) view the body after death.								
22b. SIGNATURE W.M. Smith				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 12/27/68		
22d. PHYSICIAN'S NAME (Type) W.M. Smith				22e. ADDRESS 6315 THE ALPHEA				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 28, 68		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION (City or Town) (County) (State) Frederick, Md.		
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, Towson, MD. 21204				25a. REC'D BY REGISTRAR DEC 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

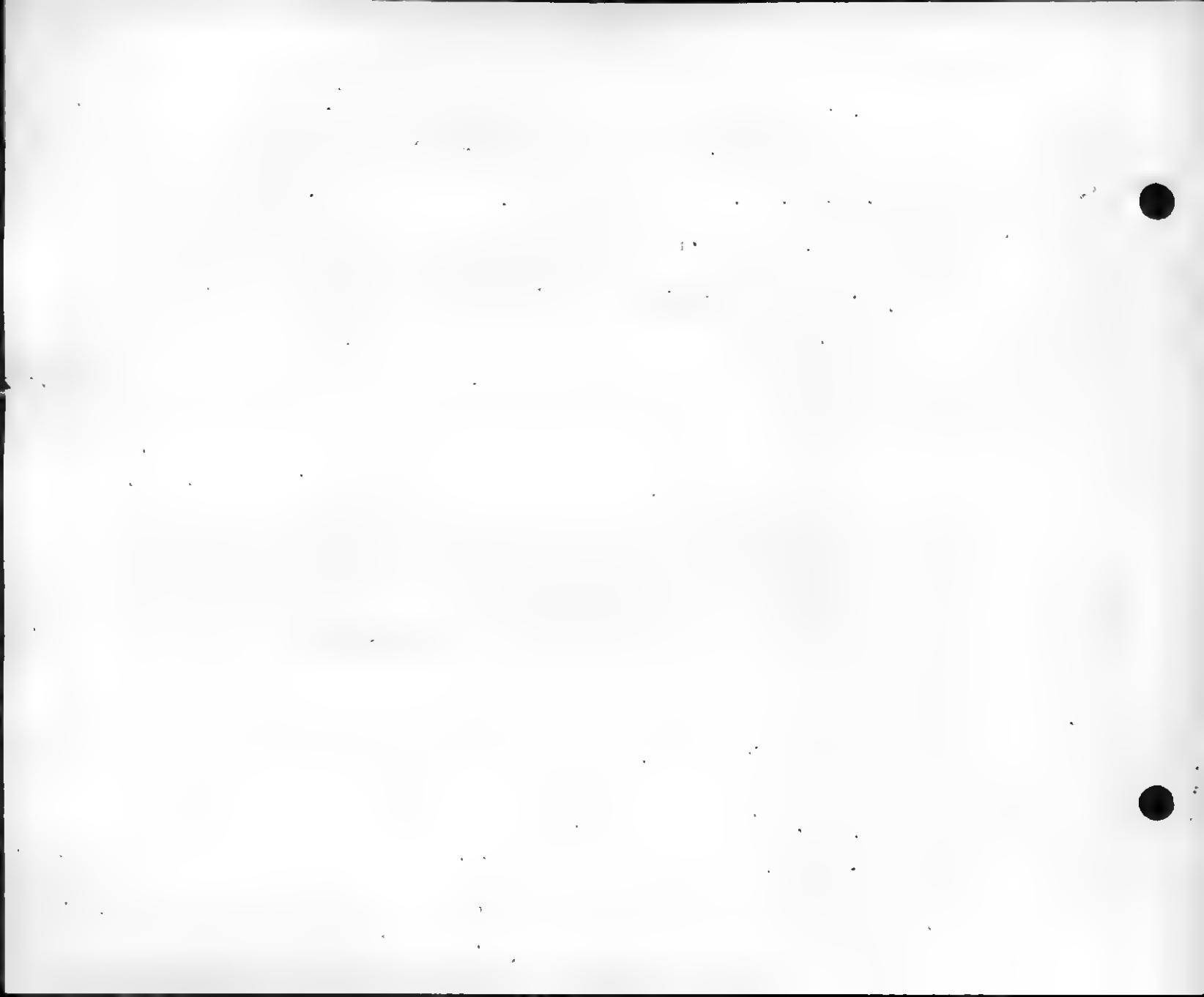


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1968

<div>17050</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>17060</div>																							
1 DECEASED-NAME (Type or print)			First Rosie			Middle B.			Last Grover			2a DATE OF DEATH Month December			Day 19			Year 1968			2b HOUR 4:00 AM		
3 SEX F			4 RACE Cauc.			5 DATE OF BIRTH 2-21-1882			6 AGE (In years last birthday) 86 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN								
7a BIRTHPLACE (State or foreign country) Frederick Co. Md.			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Baltimore Md.														
10 CITY OR TOWN OF DEATH Reistertown Rd.			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Bent Nursing Home			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY														
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b COUNTY Baltimore			13c CITY OR TOWN Finksburg			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER Rural											
14 FATHER'S NAME First William Ford			Middle Last			15 MOTHER'S MAIDEN NAME First Loretta Belt			Middle Last														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b SOCIAL SECURITY NO (If yes give war or dates of service) 217 189915			17 INFORMANT Walter F. Grover			Address 524 Fairview, Baltimore, 21224			21224											
18. CAUSE OF DEATH (Enter only one cause per line 18 (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary Heart Failure - chronic</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis - generalized</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 weeks 7 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 450C																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED 'IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a I certify that (I) (this hospital) attended the deceased from September 1968, to December 1968, that (I) (we) lost the deceased alive on December 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b SIGNATURE C. E. McWilliams MD			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 12-19-68														
22d PHYSICIAN'S NAME (Type) C. E. McWilliams			22e ADDRESS 14904 Reistertown Rd Reistertown Md																				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 12-21-68			23c NAME OF CEMETERY OR CREMATORY Fairview Methodist			23d LOCATION (City or Town) (County) (State) Towson, Baltimore, Md. 21204														
24 FUNERAL DIRECTOR Wm. Cook-Brooks			ADDRESS Towson, Towson, MD.			25a REC'D BY REGISTRAR DATE DEC 23 1968			25b. REGISTRAR'S SIGNATURE Charles Young														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
17051						17061					
1											
1 DECEASED NAME (Type or print) COLEMAN, ROYER, GRAY						2a DATE OF DEATH DEC 25 68					
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH APRIL 15 1882		6 AGE (In years last birthday) 86 YRS		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) KENTUCKY		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE COUNTY Md					
10 CITY OR TOWN OF DEATH COCKEYSVILLE				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MARYLAND MASONIC HOME				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE KENTUCKY				13b COUNTY LOUISVILLE		13c CITY OR TOWN LOUISVILLE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1508 MORTON AVE	
14 FATHER'S NAME First Middle Last NORBORNE GAY GRAY				15 MOTHER'S MAIDEN NAME First Middle Last ELLA GRAY							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b SOCIAL SECURITY NO 090-09-1630		17 INFORMANT Mid Masonic Home				Address Sec 210	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia										7 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic Vas. Heart Disease										8 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
MEDICAL CERTIFICATION											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b TIME OF INJURY HOUR A.M. Month Day Year 19 12 27 68				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f LOCATION Street or RFD No City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from Dec 1 , 19 68 , to Dec 25 , 19 68 , that (I) (we) last saw the deceased alive on Dec 25 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Carl F. Benson DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c DATE SIGNED	
22d PHYSICIAN'S NAME (Type) Carl F. Benson										22e ADDRESS 5111 York Rd. Balt. Md 21212	
23a BURIAL, CREMATION, REMOVAL (Specify) Removal				23b DATE 12-27-68		23c NAME OF CEMETERY OR CREMATORY Green Mount				23d LOCATION (City or Town) (County) (State) BALTIMORE, MD	
24 FUNERAL DIRECTOR Wm. Corp. Brooks Inc				ADDRESS 1217 St Paul St Baltimore, Md				25a REC'D BY REG. STRAR DEC 31 1968		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 418
304 REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or print) Miss Jeannette Fitzgerald Green						2a DATE OF DEATH Month Dec. Day 9 Year 1968			2b HOJR 40 P.M.				
3 SEX Female		4 RACE white		5 DATE OF BIRTH Sept. 11, 1880			6 AGE (In years lost birthday) 88 YRS		7 UNDER 1 YEAR MONTHS 0 DAYS 0		7 UNDER 24 HRS. HOURS 0 MIN. 0		
7a BIRTHPLACE (State or foreign country) Freeland Md.		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Balto.							
10 CITY OR TOWN OF DEATH Cockeysville Md.				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bonnie BLink (Plastic Home)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.				13b COUNTY Balto.		13c CITY OR TOWN Towson		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 502 Balto. Ave.			
14 FATHER'S NAME First James Middle Ellis Last Green						15 MOTHER'S MAIDEN NAME First Margaret Middle Lane Last Lane							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)				16b SOCIAL SECURITY NO NONE		17 INFORMANT Mrs Dorothy L. Young Address Rd 2 Box 61 S. Branch Rd. NECHANIC station Md.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Broncho-Pneumonia													
4129 DUE TO, OR AS A CONSEQUENCE OF (b) Arteri-sclerotic Cardiovascular Disease													
DUE TO, OR AS A CONSEQUENCE OF (c) 5 yrs													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4221													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b TIME OF INJURY HOUR A.M. 19 Month Dec Day 9 Year 1968				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)				21f LOCATION Street or RFD No. City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from Dec. 1, 1968 , to Dec. 9, 1968 , that (I) (we) last saw the deceased alive on Dec. 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE Carl F. Benson MD						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED Dec. 9, 1968					
22d PHYSICIAN'S NAME (Type) Carl F. Benson MD						22e ADDRESS 5111 York Rd Balto Md 21144							
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b DATE 12-12-68		23c NAME OF CEMETERY OR CREMATORY GOUANS Presbyterian			23d LOCATION (City or Town) (County) (State) GOUANS - MD.				
24 FUNERAL DIRECTOR Wm Cook Brooks Towson				ADDRESS 1050 York Rd Towson Md 21204				25a REC'D BY REGISTRAR DEC 12 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-41
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17053

CERTIFICATE OF DEATH

17063

1. DECEASED-NAME (Type or print) First Middle Last JOHN RAYMOND GRITZ			2a. DATE OF DEATH 12 Month 28 Day 68 Year		2b. HOUR 7:30 a.m.
3. SEX MALE	4. RACE White	5. DATE OF BIRTH March 7, 1902. 1901		6. AGE (In years) lost birthday 66 YRS	7. UNDER 1 YEAR MONTHS DAYS HOURLS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE Co. Md		
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREAT. BALT. MED. CEN.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Fireman		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 3337 Woodside Avenue
14. FATHER'S NAME First Middle Last Antony Gritz			15. MOTHER'S MAIDEN NAME First Middle Last Lena Deitz		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 215-24-4049A	17. INFORMANT Address Mrs. Margaret M. Gritz (Same)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) METASTASTIC CARCINOMA of LUNG 10x1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 100X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. col. examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (s) (this hospital) attended the deceased from 12-5 , 1968, to 12-28 , 1968, that (s) (we) lost saw the deceased alive on December 28, 1968 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Eduardo M. Canilang M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/28/68	
22d. PHYSICIAN'S NAME (Type) Dr. EDUARDO M. CANILANG M.D.				22e. ADDRESS 6701 N. Charles St. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/31/68.		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR Leonard J. Luck, Inc. Balto. Md. 21214				25a. REC'D BY REGISTRAR DATE DEC 30 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 14. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-9. A fee of \$5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17051 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17064				
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1 DECEASED-NAME (Type or Print)			First		Middle		Last			2a DATE KNOWN OF EST- DEATH MATED		2b HOUR 10A		
CHARLES			R.		GROSS						DEC 20 1968			
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month Day Year		2d HOUR 11A		
M	W	MAY 20 1896		72 YRS						DEC 20 1968				
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			Md		
PA			USA						BALTIMORE					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY					
ESSEX			2224 MONOCACY RD									R.R.		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER		
MD			BALTO.			ESSEX			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2224 MONOCACY RD		
14. FATHER'S NAME			First		Middle		Last			15. MOTHER'S MAIDEN NAME			First Middle Last	
DAVID			GROSS					ANNA WALDEMEYER						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT			ADDRESS					
UNK						MADE GROSS			ABOVE					
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-C-V Disease</u> 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4221 Diabetes Mellitus														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town			County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED 12-21-68 6800 MORNINGTON RD BUNDALE MD					
MELVIN B. DAVIS M.D.														
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
REMOVAL			12/23/68			QUICKELS			MANCHESTER PA					
24. FUNERAL DIRECTOR						ADDRESS			25a REC'D BY REGISTRAR DATE			25b REGISTRAR'S SIGNATURE		
J. E. CONNELLY SONS									DEC 24 1968			Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

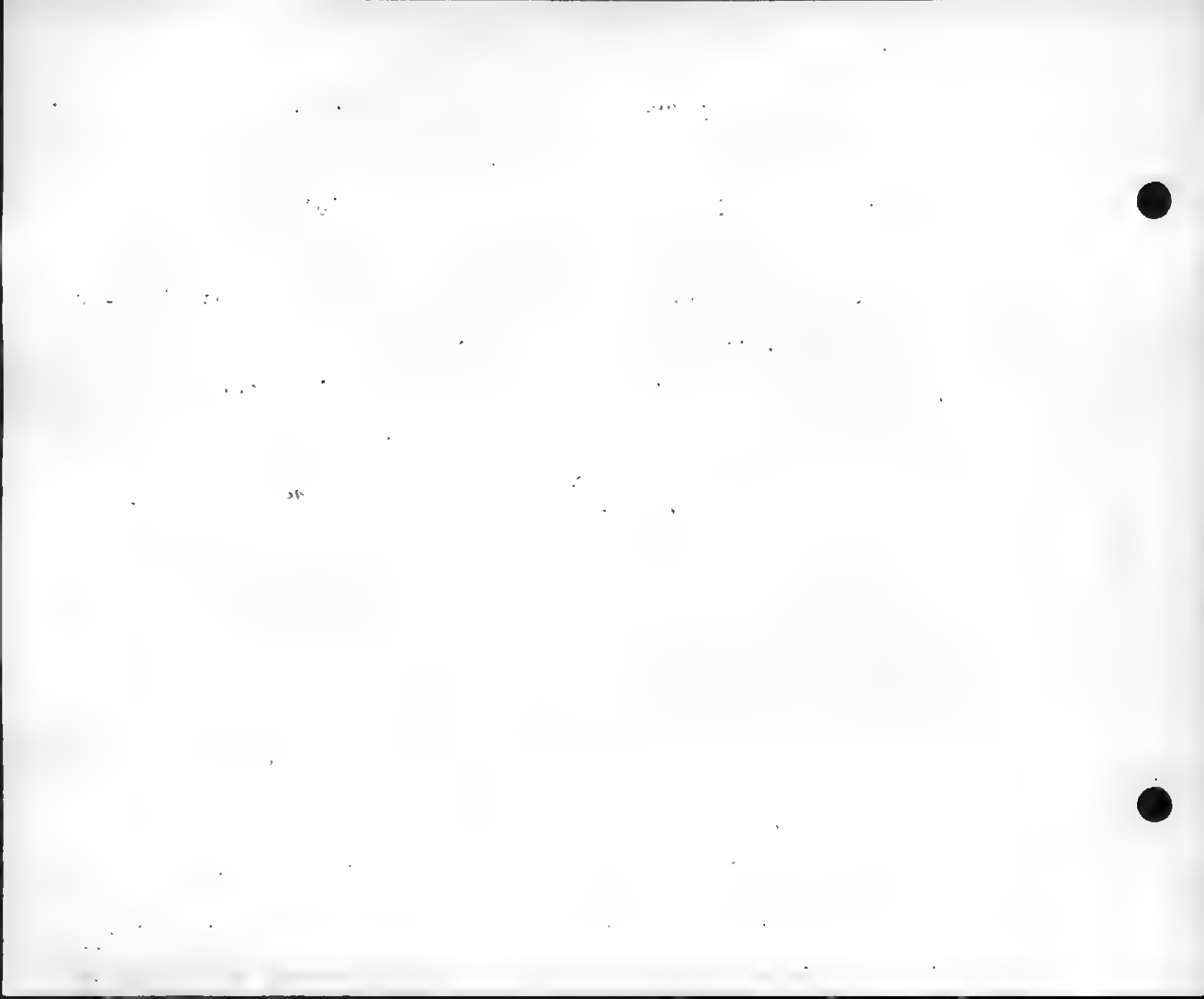
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17055
Item 10 Film 408 1/23/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17065

1 DECEASED-NAME (Type or print) RICHARD GRUBE			2a DATE OF DEATH 12/28/68 Month Day Year			2b. HOUR 9:45 a.m.			
3 SEX male		4. RACE white		5 DATE OF BIRTH 8/16/1897		6. AGE (in years lost birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.			
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3001 Woodside Ave		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) contractor		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e STREET AND NUMBER 3001 Woodside Ave.		13f. CITY OR TOWN 21234		13g. STREET AND NUMBER 3001 Woodside Ave.		13h. CITY OR TOWN 21234			
14 FATHER'S NAME Ernest Grube			15. MOTHER'S MAIDEN NAME Wilhelminia Magel			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service) no			
16b. SOCIAL SECURITY NO 213 05 7362			17. INFORMANT family records			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO OR AS A CONSEQUENCE OF (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO OR AS A CONSEQUENCE OF (c) <u>PREVIOUS CEREBRAL THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>2 1/2 YRS</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>XXX</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/3</u> , 19 <u>62</u> , to <u>12/28</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>12/28</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <u>Leonard Paul Berger</u>		22c. DATE SIGNED 12/28/68		22d. PHYSICIAN'S NAME (Type) Leonard Paul Berger		22e. ADDRESS 8100 Harford Road		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12/31/68		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION (City or Town) (County) (State) Balto. Co., Md.		23e. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR C. F. EVANS & SON		24b. ADDRESS 8802 Harford Rd.		25a. REC'D BY REGISTRAR DATE JAN 3 1969		25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

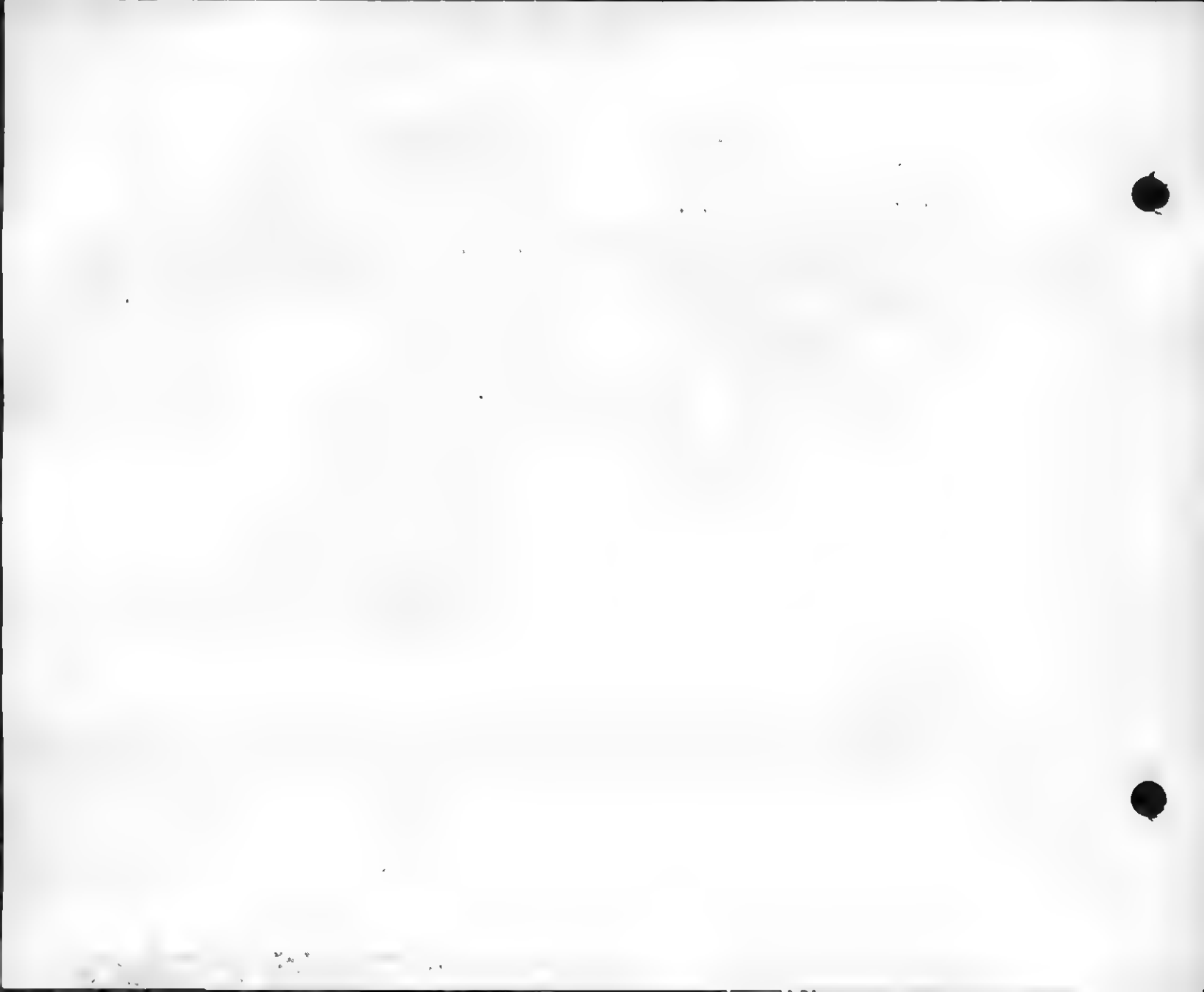
VA 15 (4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17056

17064

1. DECEASED-NAME (Type or print) First Middle Last WALTER THOMAS GUERKE			2a. DATE OF DEATH Month Day Year 12 27 68			2b. HOUR 9:55 M			
3. SEX M.		4. RACE White		5. DATE OF BIRTH May 29, 1888		6. AGE (In years last birthday) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital) GREATER BALTO. MED. CEN				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Paint	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 6818 Blenheim Rd.	
14. FATHER'S NAME First Middle Last Charles Guerke				15. MOTHER'S MAIDEN NAME First Middle Last Mary Long					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 212-18-5139 A		17. INFORMANT Mrs. Myrtle D. Guerke		Address Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST 472X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) SPONTANEOUS PNEUMOTHORAX DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC EMPHYSEMA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 6271 RESPIRATION PNEUMONIA									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12/26/68 , 19____, to 12/27, 1968 , that (I) (we) last saw the deceased alive on 12/27 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>E. Larranaga</i>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/27/68			
22d. PHYSICIAN'S NAME (Type) E. LARRANAGA, MD.				22e. ADDRESS 6701 N. CHARLES ST. BALTO. MD 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/30/68		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City or Town) (County) (State) Woodlawn Balto Md			
24. FUNERAL DIRECTOR Mitchell-Woodfield Home 6500 York Rd				ADDRESS		25a. REC'D BY REGISTRAR JAN 3 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

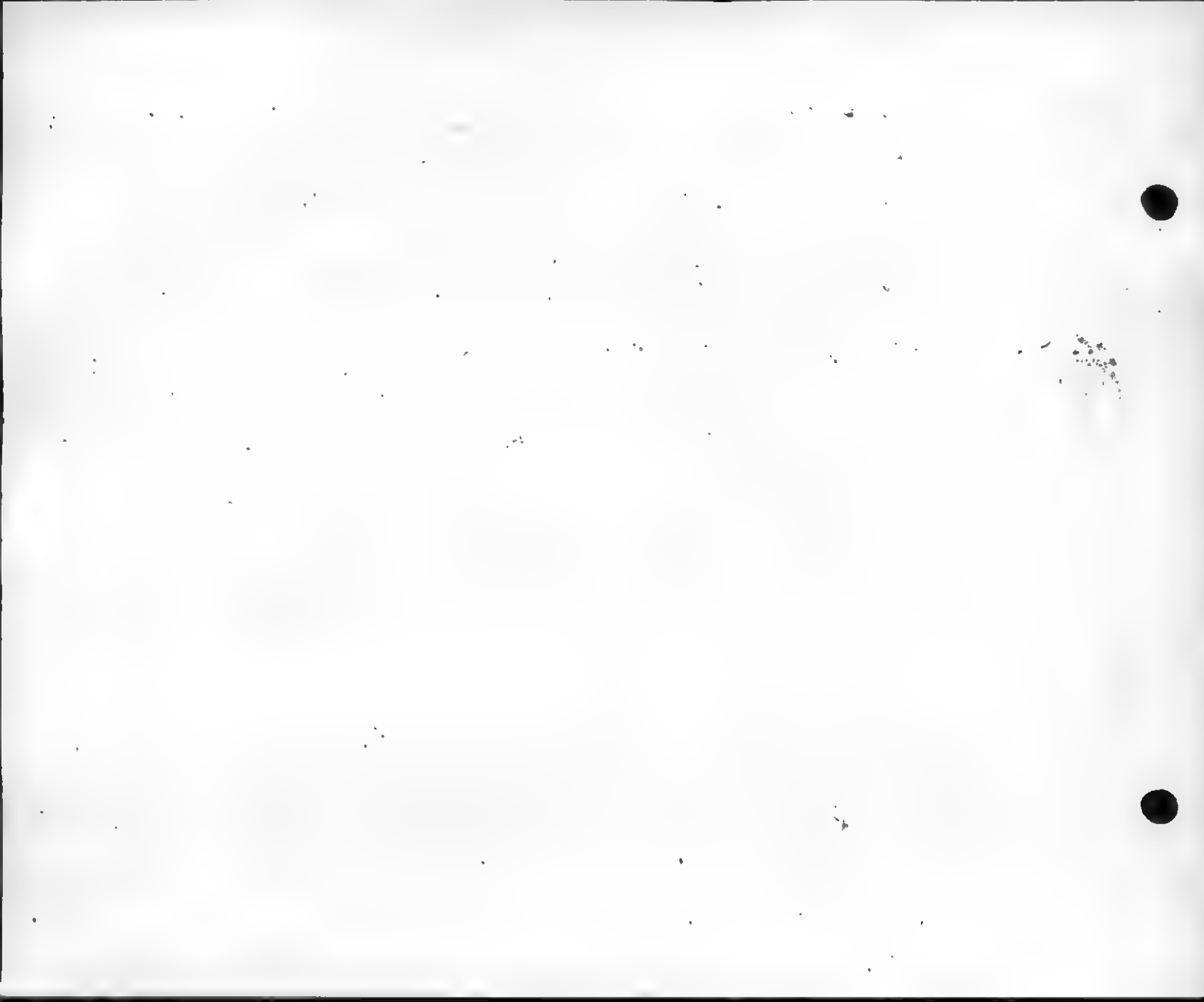


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VA 115 (4)
30M REV. 1-7-68

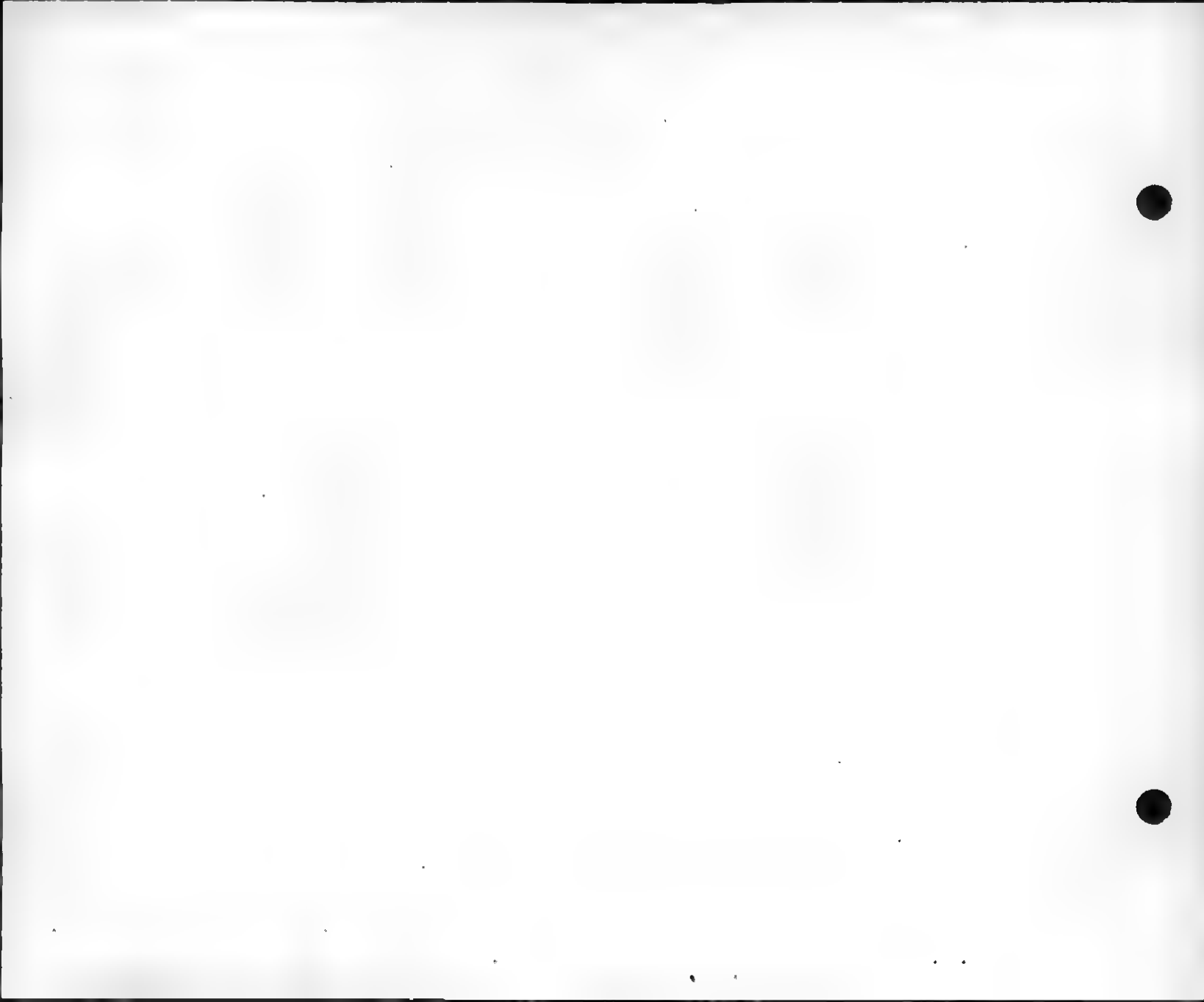
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
17057											
1. DECEASED-NAME (Type or print) SALVATORE						2a. DATE OF DEATH			2b. HOUR		
First Middle Last GUGLIUZZA						Month Day Year Dec 12 1968			11 P M		
3 SEX MALE		4 RACE White		5 DATE OF BIRTH 30 Oct 1881		6 AGE (in years last birthday) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS M. L.	
7a. BIRTHPLACE (State or foreign country) ITALY		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE Md					
1d. CITY OR TOWN OF DEATH BALTO RURAL				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 7519 Belair Road.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND				13b. COUNTY Balto.		13c. CITY OR TOWN BALTO RURAL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 7519 Belair Rd 21236	
14. FATHER'S NAME First Middle Last VINCENZO GUGLIUZZA				15 MOTHER'S MAIDEN NAME First Middle Last ROSARIA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)				16b. SOCIAL SECURITY NO 215-12-9655		17 INFORMANT Joseph GUGLIUZZA		Address 4102 Glenmore Balto 21206			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic sclerotic Cardiovascular Disease Unknt											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6 Dec 1968 , to 12 Dec 1968 , that (I) (we) lost the deceased alive on 6 Dec 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John C. Hyle MD				DEGREE MD ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 13 Dec 68			
22d. PHYSICIAN'S NAME (Type) JOHN C. Hyle				22e. ADDRESS 7527 Belair Rd 21236							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE DEC 16 1968		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY		23d. LOCATION (City or Town) (County) (State) Balto. Maryland.					
24. FUNERAL DIRECTOR D. P. P. Bro's Inc.				ADDRESS 7110 Belair Road.		25a. REC'D BY REGISTRAR 21206		25b. REGISTRAR'S SIGNATURE Charles Judge			
						DATE DEC 16 1968					



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17058		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17068	
1. DECEASED-NAME (Type or print) First Middle Last Naomi L. Haas						2a. DATE OF DEATH Month Day Year 12 7 68	
3 SEX Female		4. RACE white		5. DATE OF BIRTH 9-9-1887		6. AGE (In years last birthday) 81 YRS	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Garrison		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Fox Leigh N.H.		2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Turn Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO-W		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 211 Cedarcroft Rd.		14. FATHER'S NAME First Middle Last THOMAS LAMBDIN		15. MOTHER'S MAIDEN NAME First Middle Last BARRINGER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 215-10-5494		17. INFORMANT Bessie M. S. Verwood - 211 Cedarcroft Rd.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 411-7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Atherosclerosis and its debris DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 10-30, 1968, to 12-7, 1968, that (I) (we) last saw the deceased alive on 12-6, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d.d) (did not) view the body after death.							
22b. SIGNATURE Vickie M. Jenkins D.D.				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 12-7-68	
22d. PHYSICIAN'S NAME (Type) VICKIE M. JENKINS D.D.				22e. ADDRESS Spring Grove State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/10/68		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 1205 York Rd. Balto. 12, Md.				25a. REC'D BY REGISTRAR DEC 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Item 2 See birth cert. **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17059

CERTIFICATE OF DEATH

17069

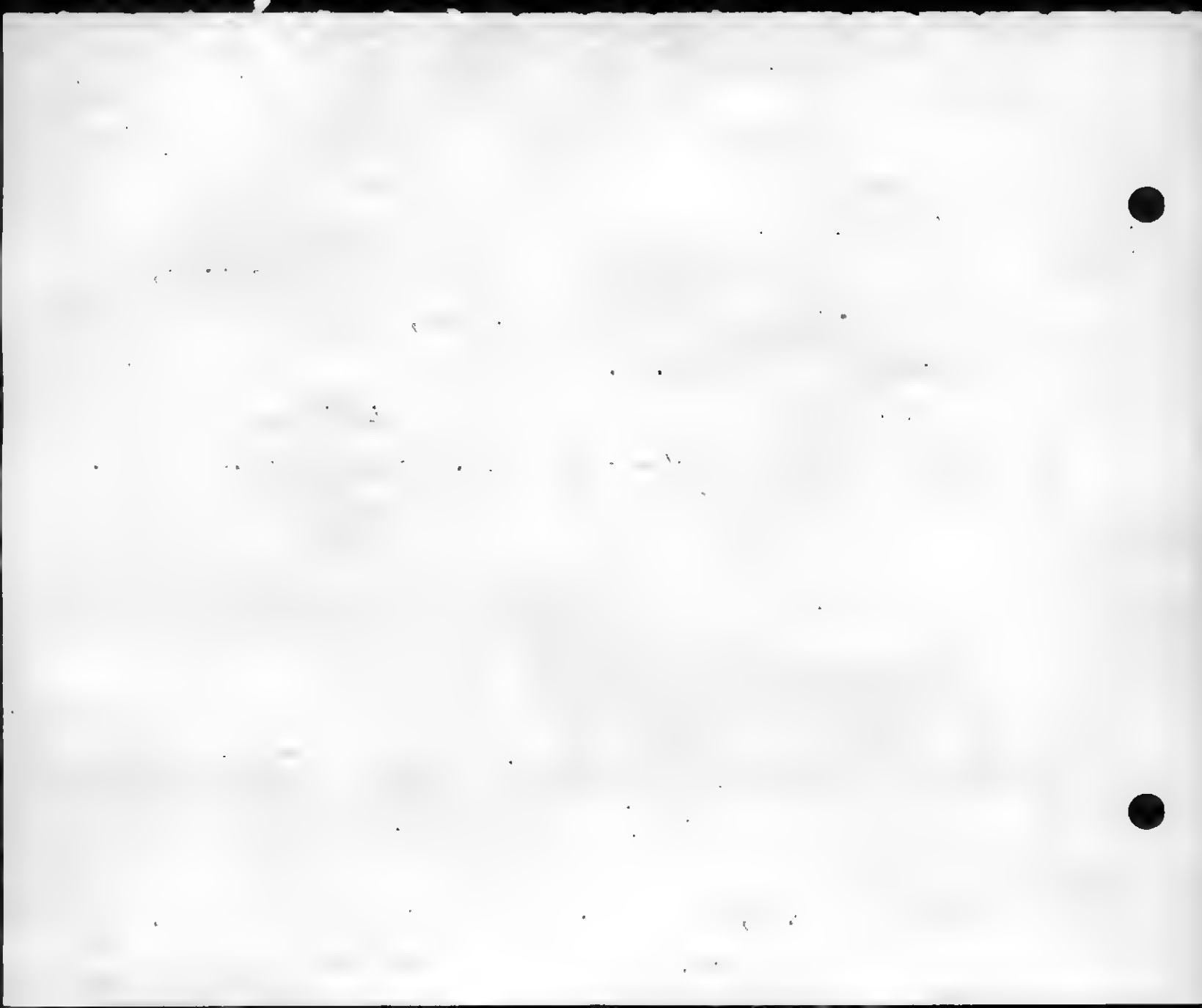
1 PLACE OF DEATH a COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville				c LENGTH OF STAY IN 1b 1433 Taylor Ave.			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8814 Baker Avenue, Balto., Md. 21234				e STREET ADDRESS 8814 Baker Avenue, Balto., Md. 21234			
3 NAME OF DECEASED (Type or print) First David Middle Haberstich Last 4. DATE OF DEATH Month 12 Day 28 Year 19 68				9 AGE (In years last birthday) yrs. 1 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min			
5 SEX Male	6. COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-28-68	10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland				12 CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME August Haberstich				14 MOTHER'S MAIDEN NAME Patricia Pirtle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Family Records Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Prematurity 11/8/2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemorrhage DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 11/15						INTERVAL BETWEEN ONSET AND DEATH 40 min.	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-28 , 19 68 , to 12-28 , 19 68 , that (I) (we) saw the deceased alive on 12-28-68 , 19 68 , and that death occurred at 11:30am , from causes and on the date stated above							
22a SIGNATURE Coral Gordon				22b DATE SIGNED 12-30-68		22c PHYSICIAN'S NAME (Type) Coral Gordon, M.D.	
22d ADDRESS 611 Park Avenue, Balto., Md. 21201				22e MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 12/30/68		23c NAME OF CEMETERY OR CREMATORY Hoy Redeemer Cem.		23d LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford road				25a REC'D BY REGISTRAR DATE DEC 31 1968		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

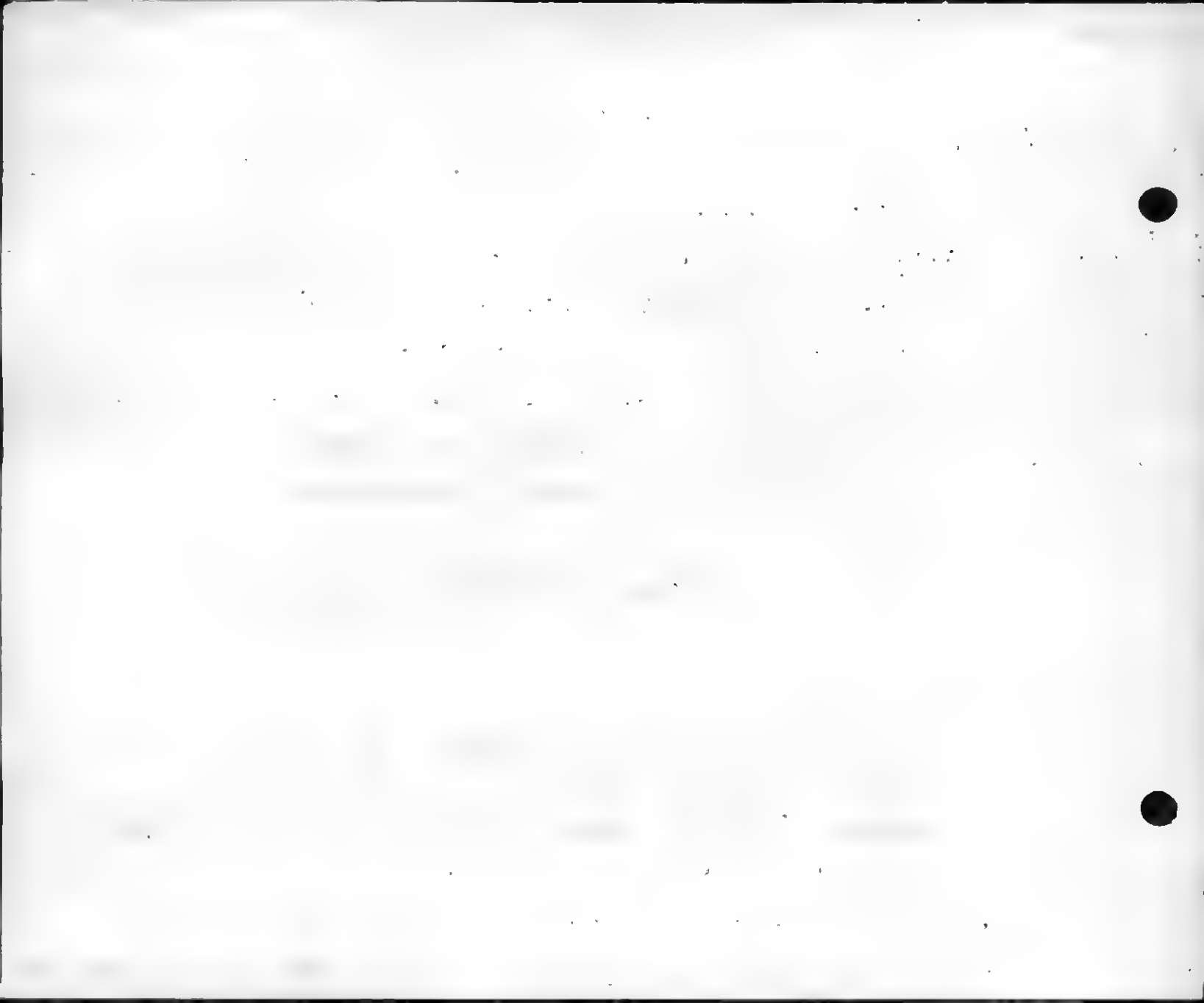
<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																	
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland b. COUNTY <u>Baltimore</u> </u>											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u>				d. STREET ADDRESS <u>1707 Roland Avenue</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1707 Roland Avenue</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Joseph Gratt Hales</u>						4. DATE OF DEATH <u>December 20, 1968</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 6, 1893</u>		9. AGE (In years last birthday) <u>75</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Draftsman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bendix Radio Corp.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Robert Hales</u>						14. MOTHER'S MAIDEN NAME <u>Jennie Pickett Fricker</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW I</u>				16. SOCIAL SECURITY NO. <u>215-22-7720</u>		17. INFORMANT <u>Mae E. Hales, Roland Ave., Ruxton, Md.</u>		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of liver</u> <u>197.0</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 13, 1956</u> to <u>Dec 20, 1968</u> that (I) (we) last saw the deceased alive on <u>Dec 16, 1968</u> and that death occurred at <u>3 AM</u> from the causes and on the date stated above.																	
22a. SIGNATURE <u>George T. Gilman</u> M.D.						22b. DATE SIGNED <u>12/20/68</u>		22c. PHYSICIAN'S NAME (Type)									
22d. ADDRESS						22e. REC'D BY REGISTRAR <u>DEC 23 1968</u>		22f. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 23, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Memorial</u>		23d. LOCATION (City, town or county) (State) <u>Cockeysville, Md.</u>											
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									



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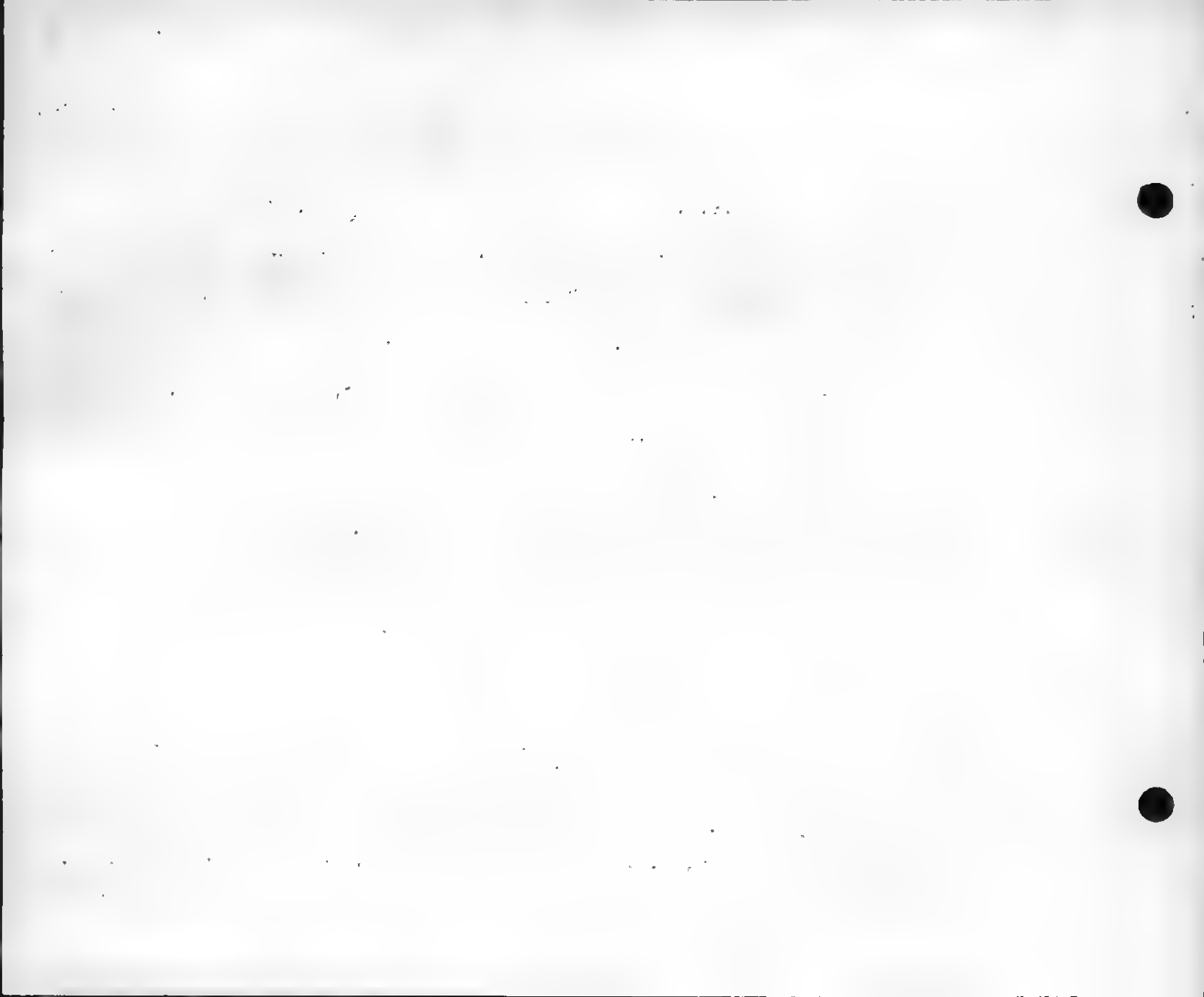
17061										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17071									
Item 13 Film 407 12/23/68 kk										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH Month Day Year					2b. HOUR M														
Bertha					L. Hall					December 6, 1968																			
3 SEX					4 RACE					5 DATE OF BIRTH					6 AGE (In years last birthday)					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS M.N.				
Female					Caucasian					Jan. 23, 1989					79 YRS.														
7a BIRTHPLACE (State or foreign country)					7b CITIZEN OF WHAT COUNTRY?					8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH														
New York					U.S.A.										BALTIMORE					Md									
10 CITY OR TOWN OF DEATH					11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY														
Towson					Armcast Nursing Home					Federal Govt.																			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b COUNTY					13c CITY OR TOWN					13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER									
Md.					Baltimore					Baltimore										3129N. Calvert St.									
14 FATHER'S NAME First Middle Last					15 MOTHER'S MAIDEN NAME First Middle Last																								
Vernon L. Hall					Mary I. Benson																								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown					16b SOCIAL SECURITY NO.					17 INFORMANT					Address														
No					218-22-0146					Adelaide Johnson, 102 W. 39th St. 21210																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>4367</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Parkinson's Disease</u>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>67</u> , to <u>Dec 6</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 1</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b SIGNATURE <u>Fannklin E. Leslie MD</u> DEGREE ATTENDING <input checked="" type="checkbox"/> MED <input type="checkbox"/> STAFF <input type="checkbox"/> NAME (Type) Fannklin E. Leslie M. D.															22c DATE SIGNED <u>12/8/68</u>														
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS																								
Fannklin E. Leslie M. D.					Marylander Apartments # 142																								
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					12-9-1968					Loudon Park Cemetery					Baltimore, Maryland														
24. FUNERAL DIRECTOR ADDRESS										25a REC'D BY REGISTRAR DATE					25b. REGISTRAR'S SIGNATURE														
Wm. Cook-Brooks Inc. 1217 St. Paul St., Baltimore, Md. 21202										DEC 12 1968					<u>f Charles Judge</u>														



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17062										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17072																													
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
First Middle Last Joan Ora HANDSCHUH										Month Day Year 12 4 68										3:35 A M																													
3. SEX Female										4. RACE White										5. DATE OF BIRTH 7/25/32										6. AGE (In years last birthday) 36 YRS.										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Baltimore Md.																			
1d. CITY OR TOWN OF DEATH Owings Mills										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Dependent										12b. KIND OF BUSINESS OR INDUSTRY none																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b. COUNTY Baltimore										13c. CITY OR TOWN Baltimore										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 128 West Burnett Street									
14. FATHER'S NAME First Middle Last Adam - Handschuh										15. MOTHER'S MAIDEN NAME First Middle Last Naomi - Wilson										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <input checked="" type="checkbox"/> NO										16b. SOCIAL SECURITY NO. none										17. INFORMANT Rosewood Records, Owings Mills, Maryland									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Pneumonia</u> 15.7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Epilepsy</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No City or Town County State																													
22a. I certify that (X) (this hospital) attended the deceased from <u>10/18</u> , 19 <u>39</u> , to <u>12/4</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>12/4</u> , 19 <u>68</u> , and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (U) (we) (did) (did not) view the body after death.										22b. SIGNATURE <i>Nevzat Turkman</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c. DATE SIGNED 12/4/68																													
22d. PHYSICIAN'S NAME (Type) Nevzat Turkman, M.D.										22e. ADDRESS Rosewood St. Hosp., Owings Mills, Md.																																							
23a. BURIAL, CREMATION, REMOVAL Burial										23b. DATE 12/7/68										23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery										23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md.																			
24. FUNERAL DIRECTOR <i>McCullough F.H.</i>										ADDRESS 237 Patapsco Ave. 21225										25a. REC'D BY REGISTRAR DEC 9 1968										25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>																			



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17073

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film 07 12/16/68

CERTIFICATE OF DEATH

17073

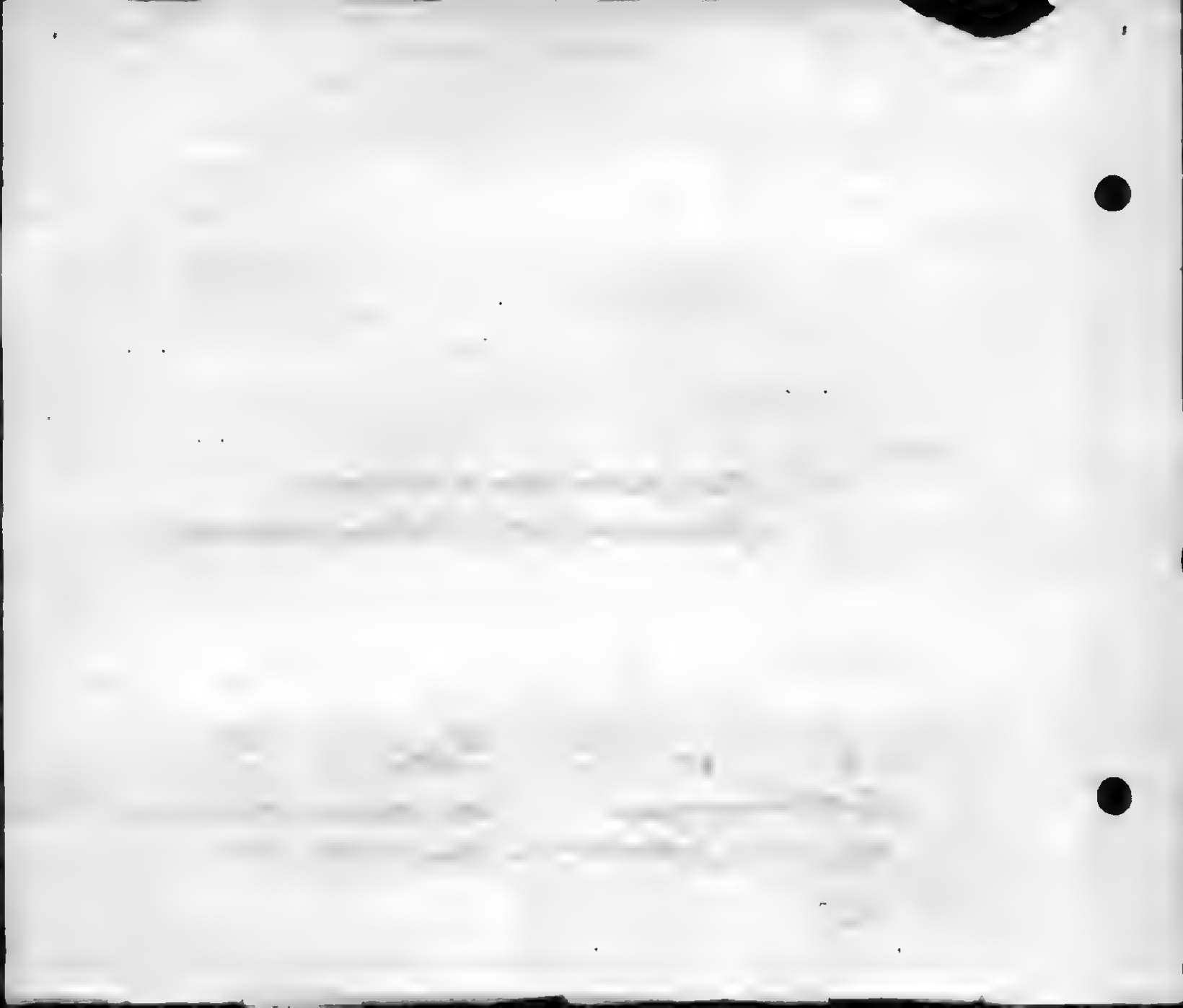
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Reside before admission) a. STATE Maryland b. COUNTY 16	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paradise Nursing Home		d. STREET ADDRESS 3501 Oakmont Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lillian Eudora Hanley		4. DATE OF DEATH Month Day Year December 23 1968	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1891
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph W. Boothe		14. MOTHER'S MAIDEN NAME Elizabeth Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Agnes Keller, Crain Courts, P.O. Box 664 21061		Address Glen Burnie Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4500		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-25 1968 , to 12-3 1968 , that I last saw the deceased alive on 12-3 1968 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 3915 HOLLINS FERRY RD		DATE SIGNED 12/3/68	
ACTUAL SIGNATURE Robertson		M.D. DOMINGO C. SORDONGON, M.D. BALTIMORE Md. 21227	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-6-1968	22c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore City, Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Ave. 21229		24a. REC'D BY REGISTRAR DATE DEC 9 1968	
		24b. REGISTRAR'S SIGNATURE Charles Judge	

X

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17064

CERTIFICATE OF DEATH

17074

1. DECEASED NAME (Type or print) KATHERINE ELIZABETH HANSEN			2a. DATE OF DEATH Month Dec Day 24 Year 68		2b. HOUR 9:20 P
3 SEX F	4 RACE WHITE	5. DATE OF BIRTH 4-13-84		6. AGE (In years last birthday) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) BALTO, MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTO Md.		
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BALTO COUNTY GEN. HOS.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD		13b. COUNTY BALTO	13c. CITY OR TOWN BALTO	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3610 Buckingham Rd
14. FATHER'S NAME First HENRY Middle Last KAISER			15. MOTHER'S MAIDEN NAME First Elizabeth Middle Yenlner Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, 198 of (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. None		17. INFORMANT Harry J. Hansen, 3610 Buckingham Rd. 21227	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 41-7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH > 24 Hours					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 42-1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.		21f. LOCATION Street or RFD No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 2-23 , 19 68 , to 2-24 , 19 68 , that (I) (we) last saw the deceased alive on 2-24 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Gregorio Marfori MD DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-24-68	
22d. PHYSICIAN'S NAME (Type) Gregorio Marfori		22e. ADDRESS Baltimore County General Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-28-68		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
23d. LOCATION (City or Town) Baltimore City, Baltimore Md.		(County)		(State)	
24. FUNERAL DIRECTOR Howard H. Hubbard 4107 Wilkens Ave. 21229		ADDRESS		25a. REC'D BY REGISTRAR DEC 27 1968	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

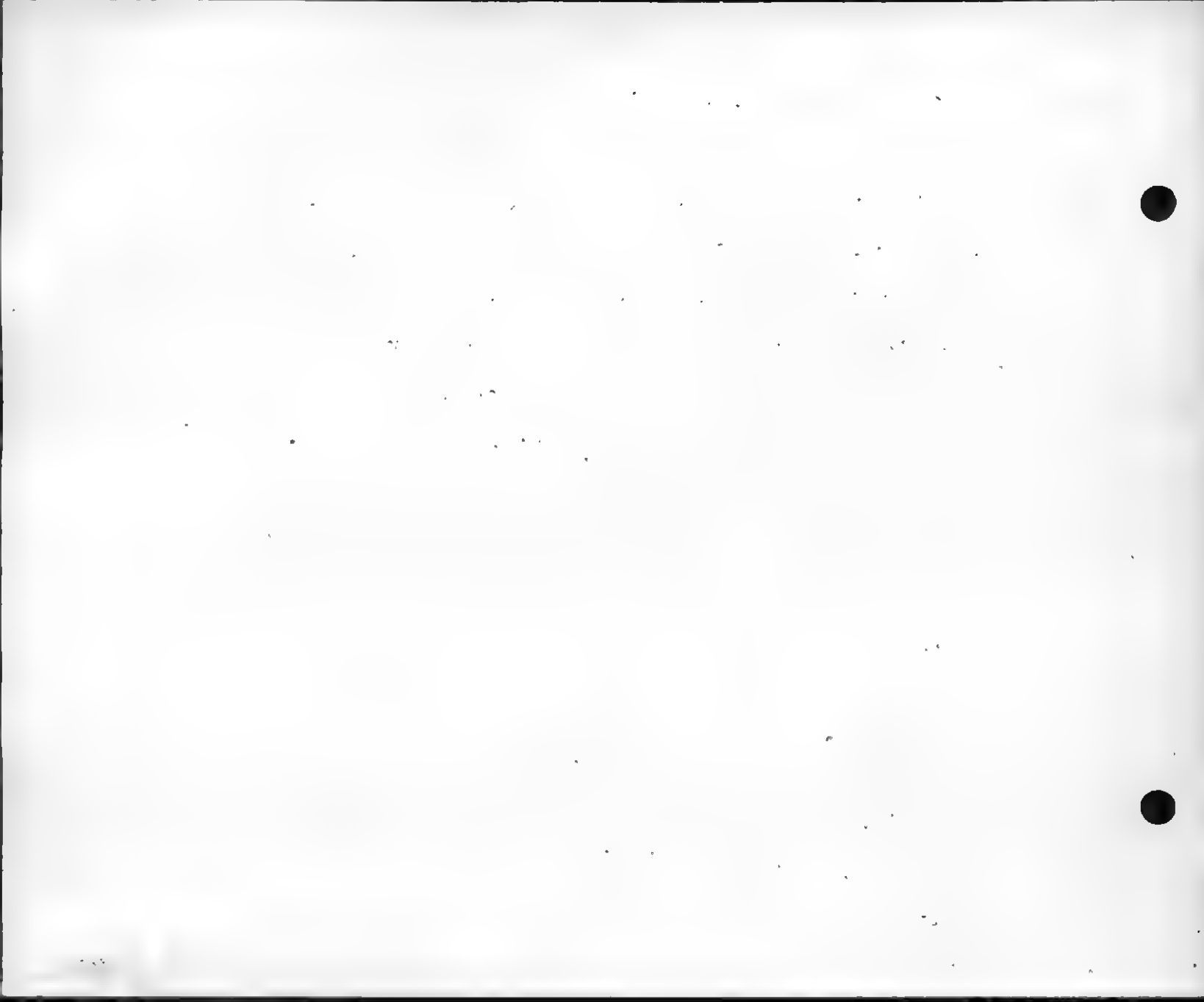
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) First Middle Last George A. Harbaugh						2a. DATE OF DEATH 12-25-1968 Day Year			2b. HOUR 6 P.M.			
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH 11-12-1891			6 AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.						
10 CITY OR TOWN OF DEATH Towson, Md.			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give place of death) Greater Balto; Medical Center			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Watchmaker			12b KIND OF BUSINESS OR INDUSTRY Jewelry			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Lutherville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 818 Kellogg Road			
14. FATHER'S NAME First Middle Last James H. Harbaugh				15 MOTHER'S MAIDEN NAME First Middle Last Mary Elizabeth ?								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes			16b. SOCIAL SECURITY NO. 212-05-7773		17. INFORMANT Address Hazel M. Jester 818 Kellogg Road							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Missile Myocardial Infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. MONTH Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY</u> , 19 <u>62</u> , to <u>DEC</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/25</u> , 19 <u>68</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.												
22b SIGNATURE <u>W. M. Smith</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/27/68				
22d. PHYSICIAN'S NAME (Type) W. M. Smith						22e. ADDRESS 6305 THE ALAMEDA						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12-30-1968		23c. NAME OF CEMETERY OR CREMATORY Hereford Baptist Church			23d. LOCATION (City or Town) (County) (State) Hereford, Maryland					
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson 1050 York Rd. 21204						25a. REC'D BY REGISTRAR DEC 30 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge				



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

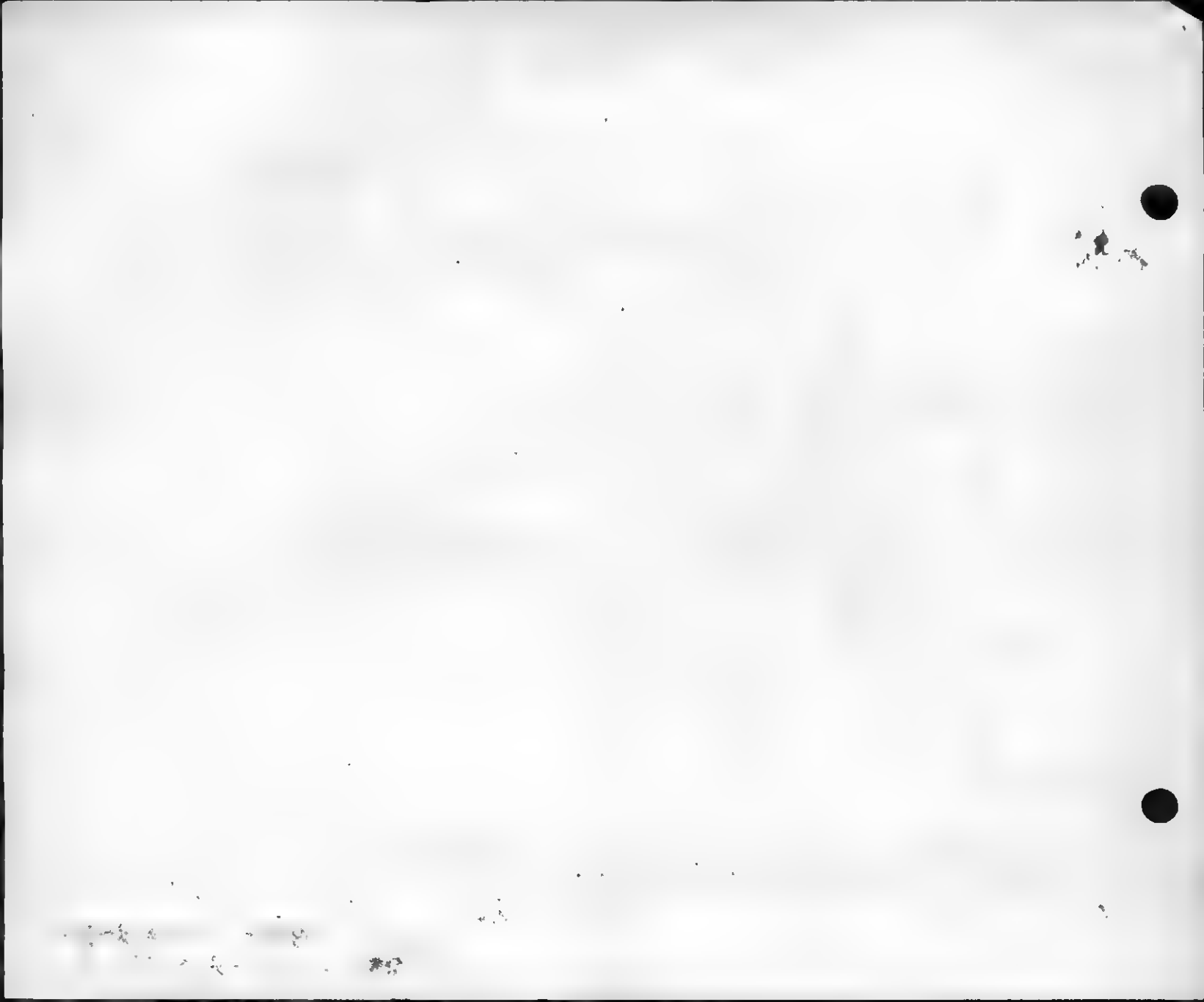
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 11 Film 08
1/3/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17076

1 DECEASED-NAME (Type or Print) First Middle Last ROBERT B. HARRIS			2a. DATE KNOWN OF DEATH Month Day Year 12 18 1968		2b. HOUR 11:45
3 SEX Male	4 RACE Negro	5. DATE OF BIRTH Aug. 11, 1916	6. AGE (in years last birthday) 52 YRS.	7c. DATE PRONOUNCED DEAD Month Day Year December 18, 1968	
7a. BIRTHPLACE (State or foreign) Lincolnton, N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto.
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 100 Lombarton Rd. 3710 Forrest Park Ave.		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3710 Forrest Park Ave.
14. FATHER'S NAME First Middle Last Irred Harris			15. MOTHER'S MAIDEN NAME First Middle Last Nannie Edwards		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 23-01-5349	17. INFORMANT Mrs. Maria Harris		
ADDRESS 3710 Forrest Park Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Final					
19a. DATE OF OPERATION Final		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Edward F. Wilson		M.D. Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE Dec. 23, 1968	23c. NAME OF CEMETERY OR CREMATORY Union National Cem.		23d. LOCATION (City or Town) (County) (State) 5501 Francis Ave. Balto. Md.
24. FUNERAL DIRECTOR Joseph E. Kline		ADDRESS 2222 W. Mount Clear		25a. DATE DEC 27 1968	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

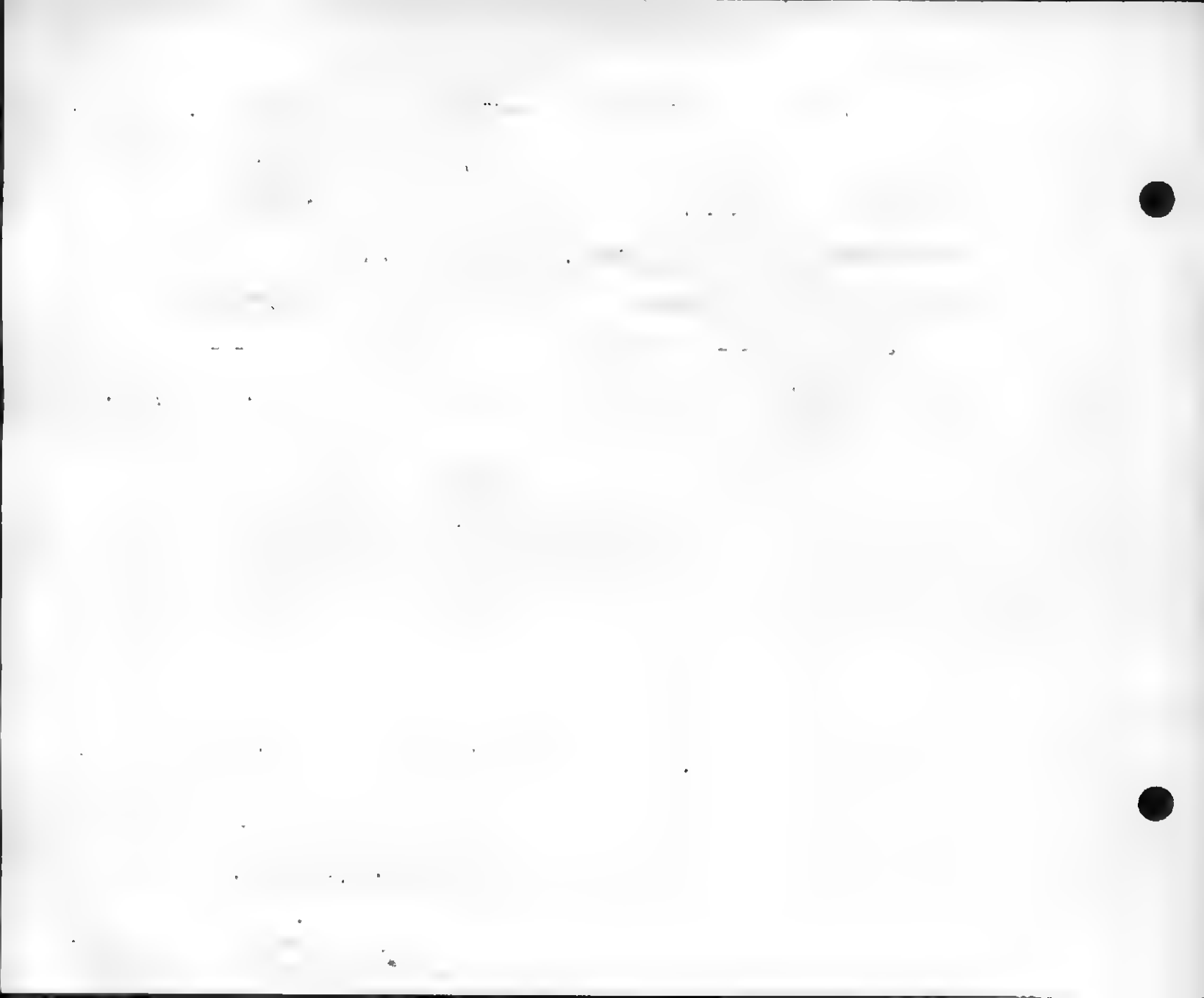
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17007

17077

1 DECEASED NAME (Type or print) First Middle Last JOHN THORNTON HARRISON			2a DATE OF DEATH Month Day Year DECEMBER 19, 1968		2b HOUR Min 7:10p
3 SEX MALE	4 RACE NEGRO	5 DATE OF BIRTH 2/7/1900		6 AGE (In years last birthday) 68 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) VIRGINIA	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH BALTIMORE		Md
10 CITY OR TOWN OF DEATH FORT HOWARD		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMIN. HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) JANITOR	
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b COUNTY ANNE ARUNDEL	13c CITY OR TOWN GLEN BURNIE	13d HOUSE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 9 SCOTT AVENUE
14. FATHER'S NAME First Middle Last JOHN - - HARRISON			15. MOTHER'S MAIDEN NAME First Middle Last MANDY - -		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) YES WWII		16b SOCIA. SECURITY NO 213 10 91 57		17 INFORMANT Address CLINICAL RECORDS, VAH, FT. HOWARD, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 1550 DUE TO, OR AS A CONSEQUENCE OF (b) HEPATOMA WITH METASTASES TO REGIONAL LYMPH NODES AND BLADDER DUE TO, OR AS A CONSEQUENCE OF (c) PORTAL CIRRHOSIS LIVER					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN OLD
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) BILE NEPHROSIS					
19a DATE OF OPERATION NOV. 11, 1968		19b CONDITION FOR WHICH OPERATION WAS PERFORMED HEPATOMA WITH METASTASES TO REGIONAL LYMPH NODES AND BLADDER		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State	
22a I certify that xx (this hospital) attended the deceased from NOV. 11, 1968 , to DEC. 19, 1968 , that xx (we) last saw the deceased alive on DEC. 19, 1968 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above xx (we) (did) not view the body after death					
22b SIGNATURE <i>Peter W. Juvan</i>				22c DATE SIGNED 12/20/68	
22d PHYSICIAN'S NAME (Type) PETER W. JUVAN, M. D.				22e ADDRESS VAH, FT. HOWARD, MD.	
23a BURIAL, CREMATION, REMOVA (Specify) BURIAL		23b DATE 12/24/68		23c NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	
23d LOCATION (City or Town) (County) (State) BALTIMORE, MD.					
24 FUNERAL DIRECTOR I. Carroll		ADDRESS HALSTEAD FUNERAL HOME		25a REG. BY REGISTRAR DEC 23 1968	
45M - 1		25b REG. BY REGISTRAR DEC 23 1968			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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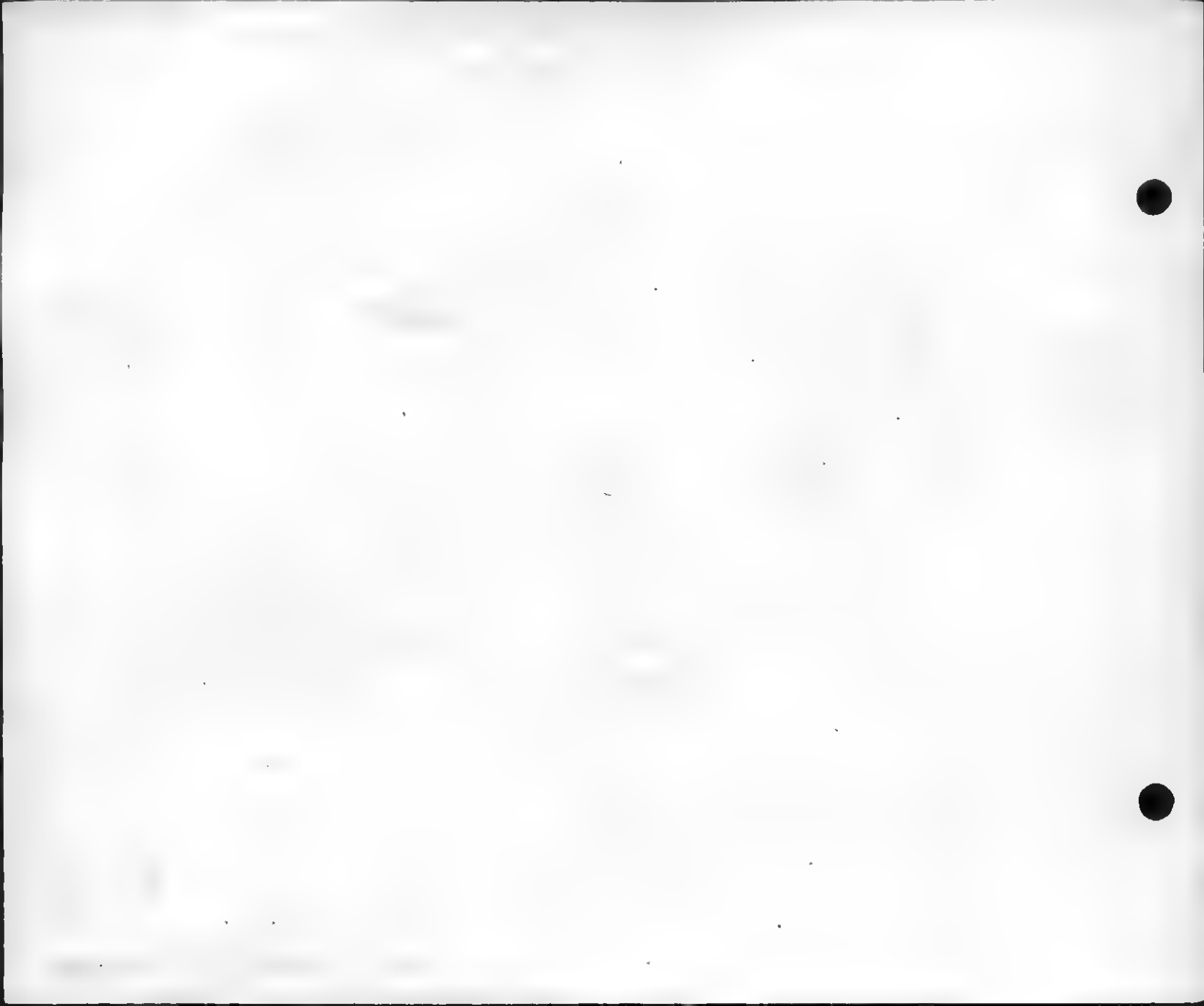
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17078

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17078

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>P</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>8 months</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (Town)</u>		d. STREET ADDRESS <u>100 Allegany Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES W. HARRON</u>		DATE OF DEATH <u>Dec 26 1968</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/13/1926</u>
9. AGE (In years, months, days) <u>42 yrs</u>		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>dentist - retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Alec D. Harrower</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Pendleton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>214-10-2899</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>485X Branch pneumonia</u> DUE TO (b) <u>485X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>485X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 or 4</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Obstructive Pulmonary Disease, Fracture of Hip</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <u>Accident - fell while walking at Spring Grove St Hospital</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>Dec 13 1968</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>J. Nelson McKay</u>		22. DATE SIGNED <u>Dec 26, 1968</u>	
EXAMINER'S NAME (Type) <u>J. Nelson McKay</u>		Address (Street, city, town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 28, 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Towson, Md.</u>
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 31 1968</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



FOR STATE HEALTH DEPT.

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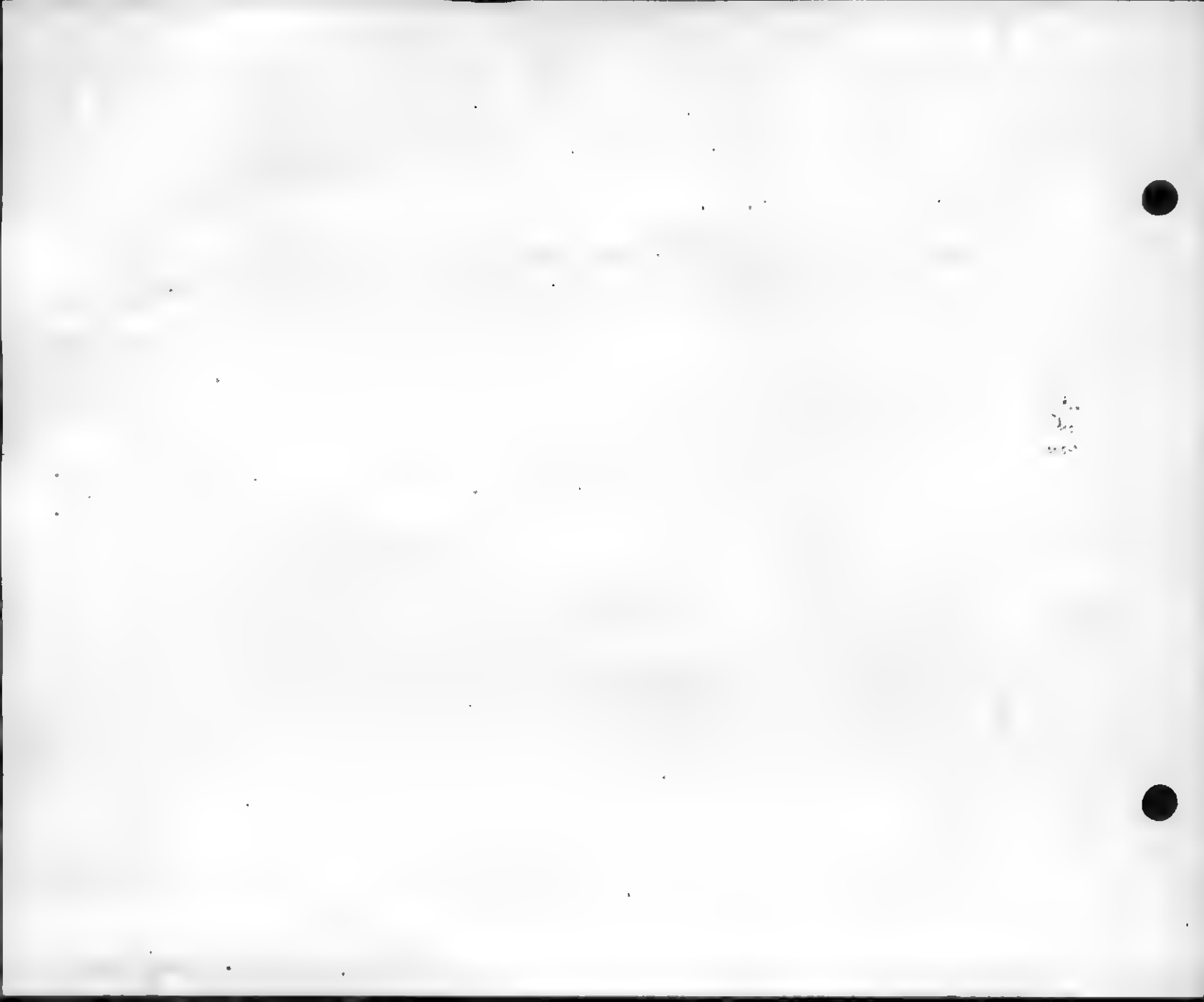
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17009

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17079

1 DECEASED NAME (Type or Print) JOHN THEODORE HART			2a DATE KNOWN OF DEATH Month DEC Day 3 Year 1968			2b HOUR OF DEATH Month DEC Day 3 Year 1968 Hour 11 PM		
3 SEX Male	4 RACE White	5 DATE OF BIRTH 6/26/1887	6 AGE (in years last birthday) 81 YRS	IF UNDER 1 YEAR MONTHS 5 DAYS 10	IF UNDER 24 HRS HOURS 11 MIN 45	2c DATE PRONOUNCED DEAD Month DEC Day 3 Year 1968 Hour 11 PM		
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE Md		
10 CITY OR TOWN OF DEATH Towson			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b COUNTY Baltimore		13c CITY OR TOWN Baltimore	3d INSIDE CITY, Y.M.S? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 2904 Park Terrace	
14 FATHER'S NAME First George Middle Hart Last Hart				15 MOTHER'S MAIDEN NAME First Anna Middle Fleckenstein Last Fleckenstein				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO		17 INFORMANT Mrs. Elizabeth Williams, 2904 Park Terrace			
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (b) RIGHT PARIETAL SKULL FRACTURE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 HRS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 7 HOUR A.M. 12/3 P.M. 1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) FELL - AT HOME				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) HOME		21f LOCATION Street or R.F.D. No. City or Town 2904 PARK TERR. PARKVILLE		County BALTO. State MD.		
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE William A. Piuschke				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED 12/4/68		
EXAMINER'S NAME (Type) William A. Piuschke				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) 4100 W. 1st St. Baltimore, Md.		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 12/7/68		23c NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Md.		
24 FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road.				25a REC'D BY REGISTRAR DEC 11 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. See Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

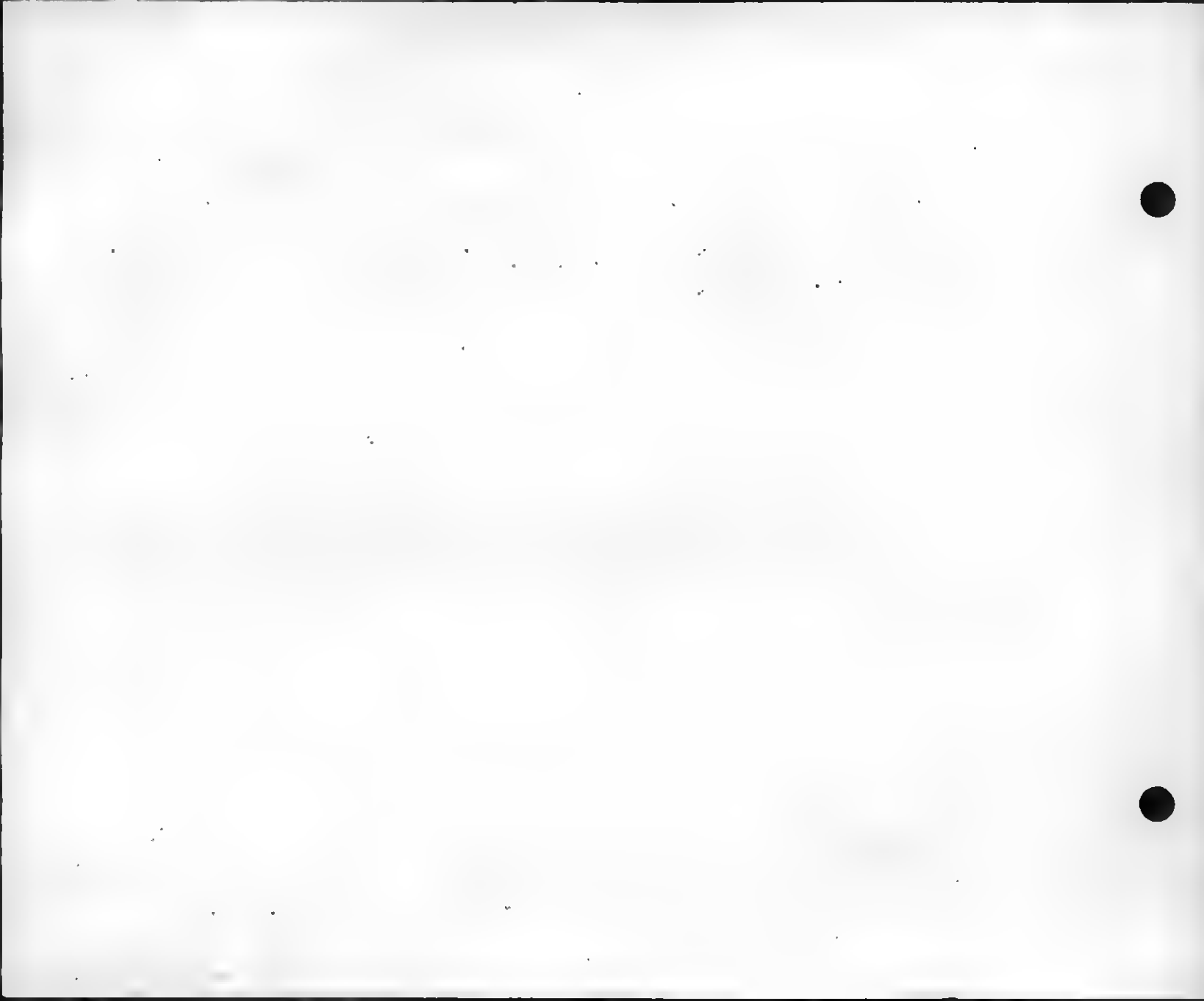
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17070

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17080

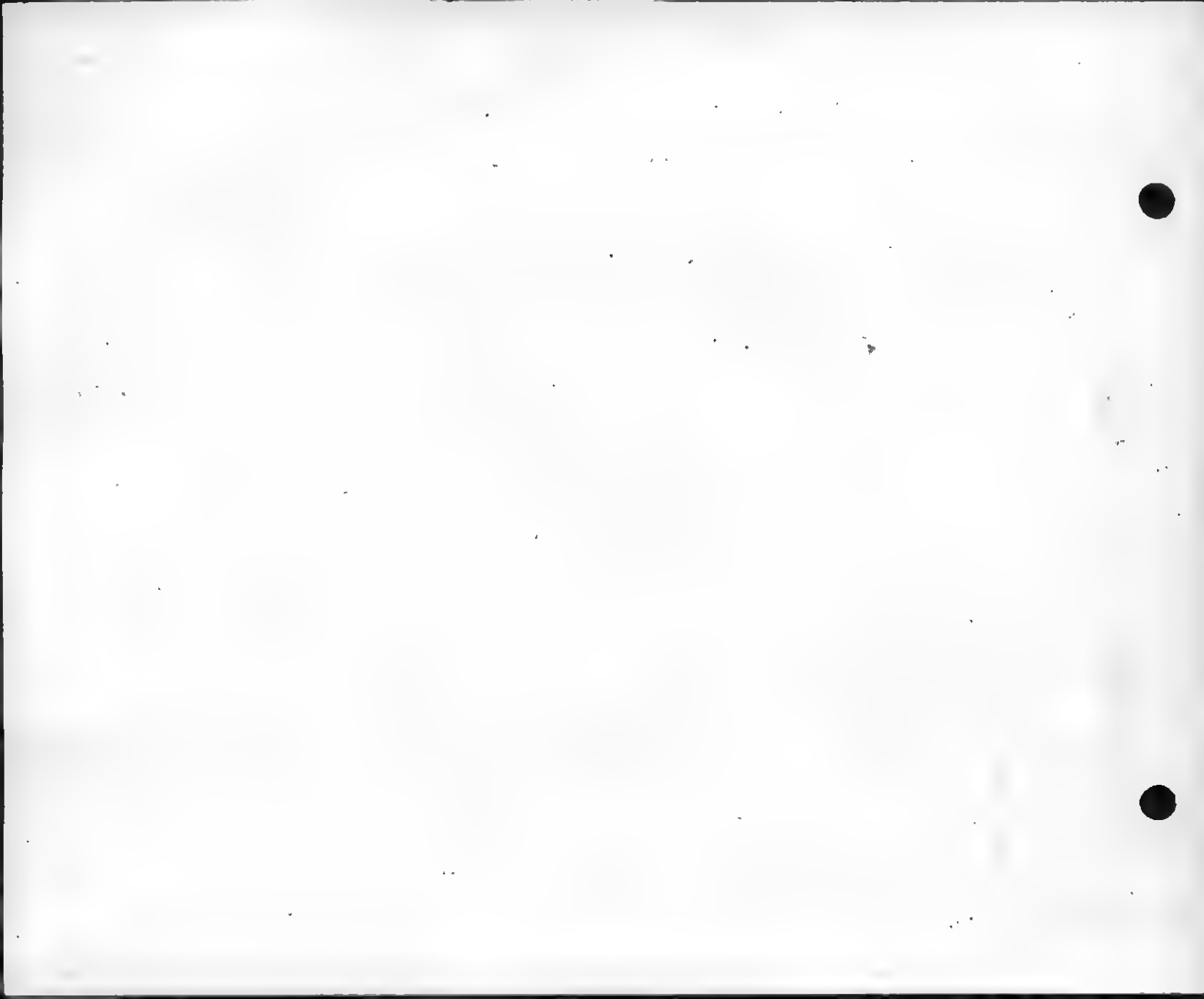
1 DECEASED NAME (Type or Print) JOHN ADOLPH HARTMAN			2a DATE KNOWN OF ESTI-DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year Dec 30 1968			2b HOUR 10:00 AM
3 SEX MALE	4 RACE White	5 DATE OF BIRTH 12 Sept 1903	6 AGE (In years last birthday) 65 YRS	IF UNDER 1 YEAR MONTHS 5 DAYS 	IF UNDER 24 HRS HOURS MIN 	2c DATE PRONOUNCED DEAD Month Dec Day 30 Year 1968
7a BIRTHPLACE (State or foreign country) OHIO		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE
10 CITY OR TOWN OF DEATH White Marsh Md		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Box 892 Carrington Dr. White Marsh Md		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Inspector		12b KIND OF BUSINESS OR INDUSTRY Beth. Steel
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before last entry in town admission) STATE Md		13b COUNTY Balto		13c INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13d STREET AND NUMBER 3x892 Carrington Dr
14. FATHER'S NAME First John Middle Last Hartman			15 MOTHER'S MAIDEN NAME First Regina Middle Geborne Last Schober			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) N/A		16b SOCIAL SECURITY NO 213 075894		17 INFORMANT ADDRESS Geo. Henry Hartman 2726 Moorgate Rd		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUT and Emphysema						undet.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
(b) DUE TO, OR AS A CONSEQUENCE OF						
(c) DUE TO, OR AS A CONSEQUENCE OF						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a DATE OF OPERATION 7-2		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE EXAMINER'S NAME (Type) JOHN C. HYTE MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 12-30-68		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 1/2/69		23c NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		
24 FUNERAL DIRECTOR Schimunek Funeral Home		25a REC'D BY REG STRAR JAN 2 1969		25b REG. STRAR'S SIGNATURE Charles J...		
23d LOCATION (City or Town) Balto., Md.		23e LOCATION (County) Balto., Md.		23f LOCATION (State) Balto., Md.		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) ROLAND ZACHARIAH HARVEY						2a. DATE OF DEATH 12 Month 11 Day 1968 Year			2b. HOUR 7:05 AM		
3. SEX male		4. RACE white		5. DATE OF BIRTH 2/24/1902			6. AGE (in years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS M.N.
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Baltimore County, Md.					
10. CITY OR TOWN OF DEATH Mount Wilson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson St. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1512 Boydsdale Street	
14. FATHER'S NAME First Zachariah Middle Harvey Last Collins				15. MOTHER'S MAIDEN NAME First Margaret Last Collins							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO 212-12-4298		17. INFORMANT Address Records, Mt. Wilson State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Glaucoma, B. lateral										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos. 1 yrs. 12 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pulmonary Tuberculosis (minimal) with Rt. pleural effusion											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 9/27/1968 to 12/11/1968 , that (I) (we) last saw the deceased alive on 12/11/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W. Newcomer						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/11/68.			
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.						22e. ADDRESS Mount Wilson, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-14-68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) Barto, Md.		(County) (State)			
24. FUNERAL DIRECTOR John H. Hahn Funeral Home, 4301 Pennington Ave.		ADDRESS		25a. REC'D BY REGISTRAR DEC 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

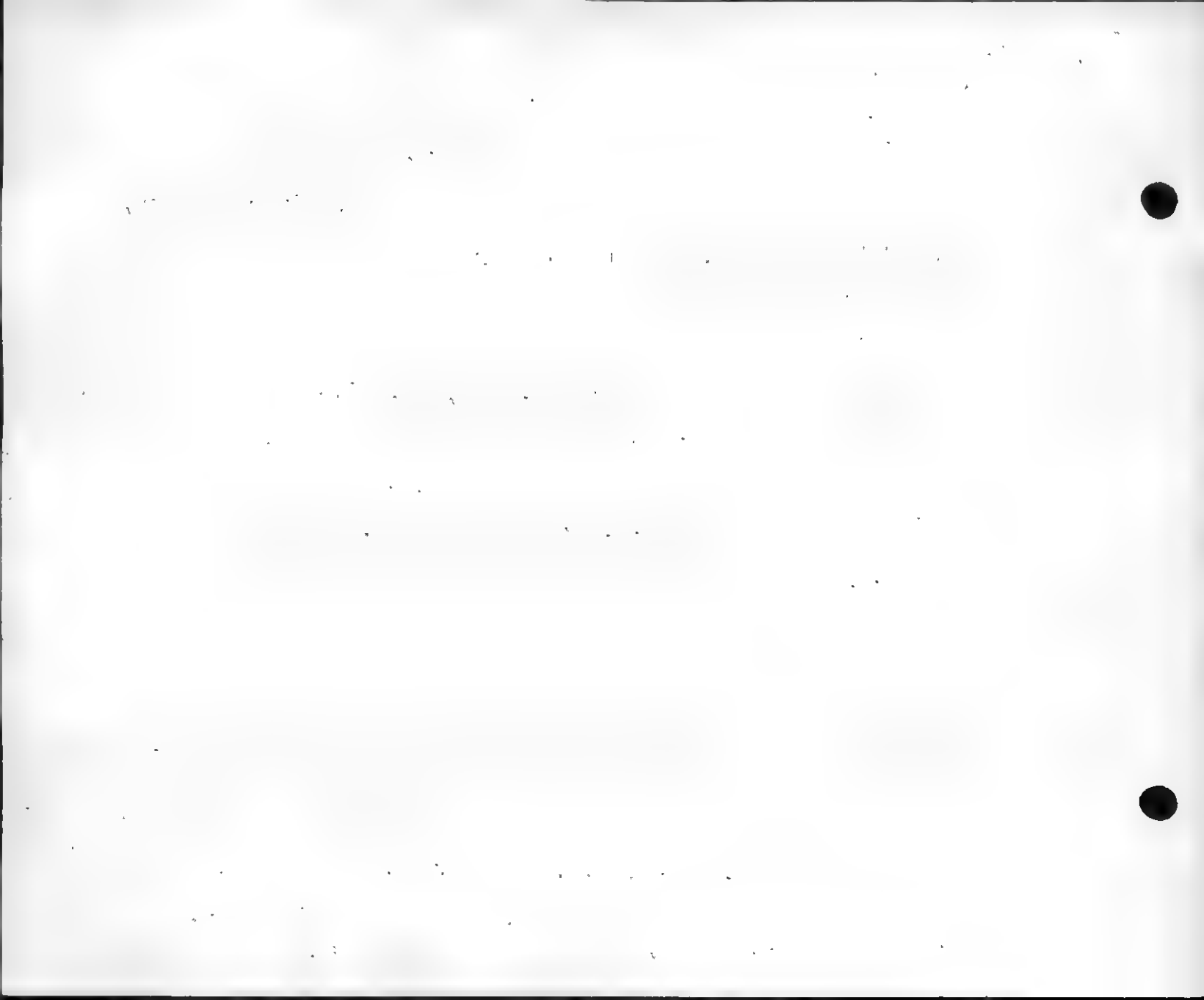


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED NAME (Type or print)				First		Middle		Last		2a. DATE OF DEATH				2b. HOUR	
JOSEPH				E.		HASKELL		12 - 19 - 1968				8:55 AM			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
male		white		11/23/1880				38 YRS.		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH									
MD. - U.S.A.		U.S.A.				Baltimore County, Md									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Mount Wilson				Mt. Wilson St. Hosp.				Capt. Fire Department							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
MD.				Balto.		Baltimore		YES		935 Astwood Rd.					
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME					
George				Haskell						Mary Hamilton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT Address									
no				218-26-0372		Records, Mt. Wilson State Hospital									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis (probable).</u>															
7109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>Generalized Arteriosclerosis</u>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic Bronchitis - Pulmonary Emphysema</u>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>11/22/1968</u> to <u>12/19/1968</u> , that (I) (we) last saw the deceased alive on <u>12/19/1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>W. Newcomer</u>												22c. DATE SIGNED <u>12/19/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>William Newcomer, M.D.</u>												22e. ADDRESS <u>Mount Wilson, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial				12/23/68		Holy Redeemer				Baltimore, Md.					
24. FUNERAL DIRECTOR <u>Witzke, 4101 Edmondson Ave. 21229</u>						25a. REC'D BY REGISTRAR <u>DEC 23 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

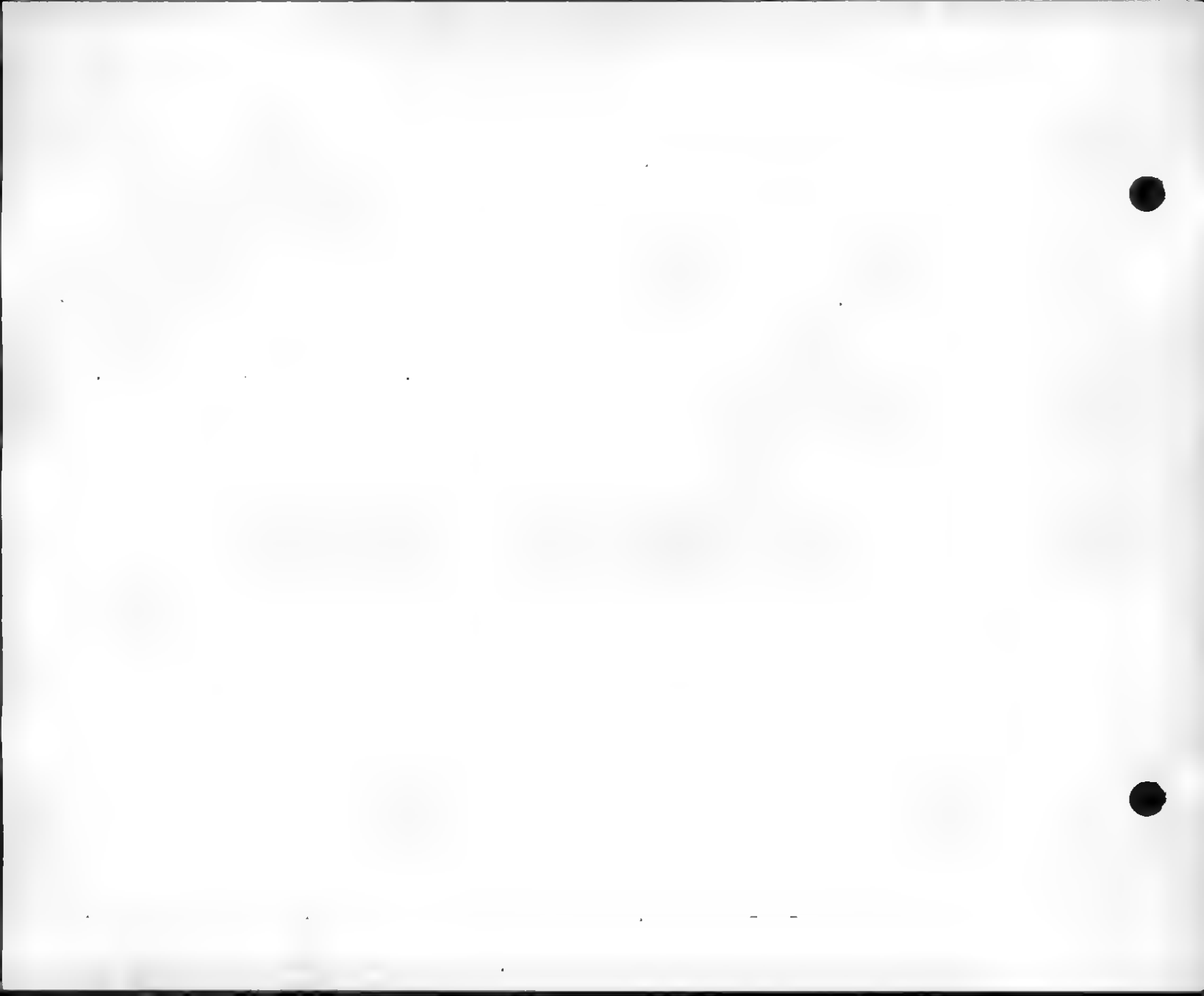


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Name			E Hatter			Month Day Year Dec 14 68			7:15 PM
3 SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female	White		3/27/87			61 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Penna.		U.S.A.				Baltimore County Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Randallstown			Balto Co Gen H			At Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.			Balto.		21207		4120 Villa Nova Rd.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Frederick Miller									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. IMPORTANT INFORMATION				
No					William H. Hood-4120 Villa Nova Rd. 21207 XXXXXXX Balto XXXX Gen Hosp				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>AORTIC ANEURYSM</u>									3 months
4120 DUE TO, OR AS A CONSEQUENCE OF (b) <u>HCUD</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
441									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes.</u>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>B. Vanasin</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Boon VANASIN		Balto County Gen Hosp.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12-18-68		Nisky Hill Cemetery		Bethlehem Pennsylvania			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Ellsworth Armacost-4600 Liberty Hghts. Ave				DEC 20 1968		<u>J. Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

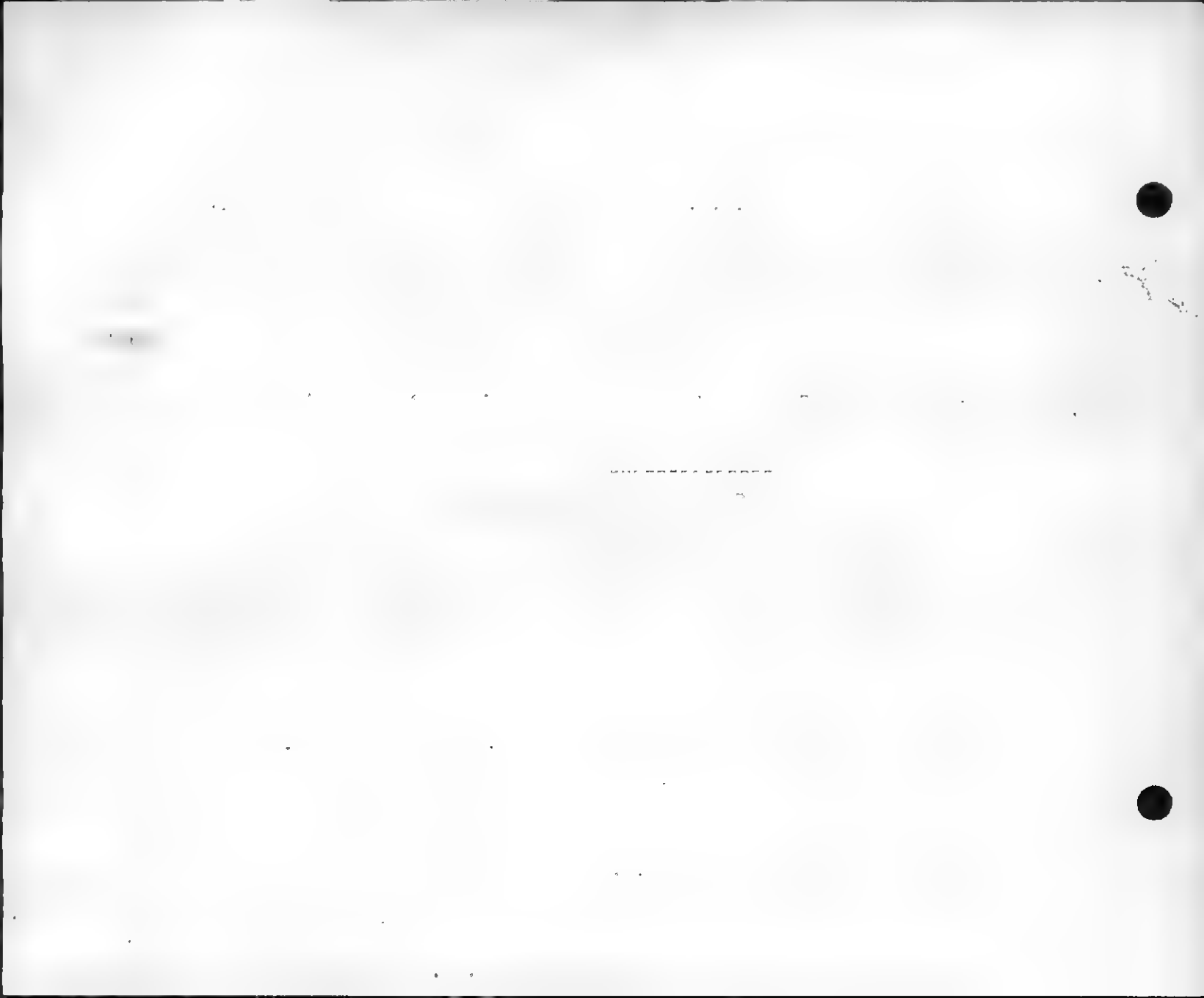
17074

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17084

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH		2b HOUR	
GEORGE				HAUSNER	12 Month 10 Day 68 Year		7:50AM	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS	
MALE	WHITE		5/20/95		73 YRS			
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND	U.S.A.				BALTIMORE COUNTY,		Md.	
1D. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a U.S.A. OCCUPATION (Kind of work done during most of work life, if registered)		12b KIND OF BUSINESS OR INDUSTRY		
FORT HOWARD		VET. ADM. HOSPITAL, FT HOWARD, MD.		ENGINEER		U.S. GOVERNMENT		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MARYLAND				BALTIMORE		408 S. CLINTON STREET		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
ALOIS		HAUSNER		JOHANNA		BIHLER		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17 INFORMANT		Address		
YES		WW-1		CLIN. REC., VAH, FT. HOWARD, MARYLAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MALIGNANCY OF GASTROINTESTINAL TRACT WITH								
159X DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
ASCITES AND METASTASIS TO OMENTUM								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or RFD No City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from 9/9/68, 19 to 12/10/68, 19, that (I) (we) last saw the deceased alive on 12/10/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.								
22b SIGNATURE		22c. DATE SIGNED						
<i>Sung Ill Shin</i>		12/10/68						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
SUNG ILL SHIN, M.D.		VAH FORT HOWARD, MARYLAND						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
BURIAL		12/13/68		MORELAND MEMORIAL CEMETERY		BALTIMORE MARYLAND		
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
Schimunek Funeral Home		DEC 16 1968		<i>Charles Judge</i>				
3331 Brehms Lane, Balto. Md.								



CERTIFICATE OF DEATH

1. NAME OF DECEASED

Type or Print

Mary K. Hearney

2. DATE AND HOUR OF DEATH

Dec. 22, 1968

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

BALTIMORE COUNTY

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

413 Academy Rd. Catonsville, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

Baltimore

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Catonsville

YES ☐NO ☒

E. STREET AND NUMBER

413 Academy Road

SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

9-20-1895

9. AGE (In years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

New Jersey

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Patrick Sullivan

14. MOTHER'S MAIDEN NAME

Mary

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Mary R. Wilhide, 413 Academy Road 21228

18.

I 413
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last, 4

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

3 days

11 years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL

22. I certify that (I) (this hospital) attended the deceased from March 1968 to Dec. 22 1968

that (I) (we) last saw the deceased alive on Dec. 21 1968 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Kennard Yaffe MD

DEGREE

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

12/22/68

23C. PHYSICIAN'S
NAME (Type)

Kennard

Yaffe

DEGREE

23D. ADDRESS

5501 Forest Park Ave Balt, Md 21207

24A. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12-24-68

24C. NAME OF CEMETERY OR CREMATORY

Calvary Cemetery

24D. LOCATION

(City, town, or county)

(State)

Newburgh, New York

25A. DATE REC'D BY HEALTH DEPT.

DEC 23 1968

25B. NAME OF REGISTRAR

Charles Judge

25C. FUNERAL DIRECTOR

ADDRESS

Howard H. Hubbard Funeral Home
4107 Wilkens Ave. Baltimore, Md. 21229TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation or removal and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 5 Film 407 12/1/68 kk		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		17076		17086	
1 DECEASED-NAME (Type or print)				First Middle Last		2a. DATE OF DEATH	
Lillian Elizabeth Heim						Month Day Year December 1 68	
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)	
Female		White		12-9-1887 1886		81 YRS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
Maryland		U.S.A.				Baltimore Md.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson		St. Joseph Hospital		Housewife		At Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Baltimore		Parkville		3044 Edgewood Ave., -21234	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last			
Frederick M. Ller				Bertha - - -			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, in () or unknown () (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No				Luther Heim		Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> +319 DUE TO, OR AS A CONSEQUENCE OF (b) <u>arterio sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>last</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat wh. le <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/19/</u> , 19 <u>68</u> , to <u>12/1/</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/1/</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Jamie M. Langeland MD</u>						22c. DATE SIGNED <u>12-1-68</u>	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS	
						7620 York Rd., Towson Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		12-4-68		Loudon Park		BALTO Md	
24 FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Chas. F. EVANSTON				DATE DEC 3 1968		William J. J...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
30M REV 1/68

Item 18 Film 407 12-23-68 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17087

1. DECEASED NAME (Type or print) Helen A. Hemming			2a. DATE OF DEATH Month 12 Day 13 Year 1968			2b. HOUR 2:00 P.M.	
3. SEX F		4. RACE W		5. DATE OF BIRTH 5/28/1902		6. AGE (In years last birthday) 66 YRS.	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Catoxville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit W.H.M.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Bookkeeping		12b. KIND OF BUSINESS OR INDUSTRY	
13a. U.S.A. RESIDENCE (Where deceased lived if institution: Residence before admission) STATE md.		13b. COUNTY --		13c. CITY OR TOWN Burdingholme		13d. INS DE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 700 Pubbing Place		14. FATHER'S NAME First Joseph P. Middle Crochmal Last ---		15. MOTHER'S MAIDEN NAME First --- Middle --- Last Fisher			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO ---		17. INFORMANT CALVIN GROCHMAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic malignancy 174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF from Breast (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) ---							
19a. DATE OF OPERATION 11-11-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year 1968 P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from August 1968 to Dec 15, 1968 , that (I) (we) last saw the deceased alive on 11/23/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (old) (did not) view the body after death							
22b. SIGNATURE R. Williams		22c. DATE SIGNED 12-13-68		22d. PHYSICIAN'S NAME (Type) ---		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12/16/68		23c. NAME OF CEMETERY OR CREMATORY WESTERN		23d. LOCATION (City or Town) (County) (State) BALTO. MD.	
24. FUNERAL DIRECTOR E.S. MACNABB		ADDRESS 21228		25a. REC'D BY REGISTRAR DATE DEC 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 1554
300M REV. 11-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																																															
<div>17078</div> <div>Items#7a,b, & 8 Film G407 12/9/68</div> <div>CERTIFICATE OF DEATH</div> <div>17088</div>																																															
1 DECEASED-NAME (Type or print)						First			Middle			Last			2a DATE OF DEATH			2b. HOUR																													
John						Edward			Hennegan			12			Month			3			Day			68			Year			8:15			a.m.														
3. SEX			4 RACE			5. DATE OF BIRTH						6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS																													
Male			White			12/28/05						62			YRS			MONTHS			DAYS			HOURS			MIN.																				
7a BIRTHPLACE (State or foreign country)						7b. CITIZEN OF WHAT COUNTRY?						8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9 COUNTY OF DEATH																													
Maryland						USA												Baltimore						Md.																							
10 CITY OR TOWN OF DEATH						11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)						12b. KIND OF BUSINESS OR INDUSTRY																													
Towson						Greater Balto. Med. Center																																									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE						13b. COUNTY						13c. CITY OR TOWN						13d. INSIDE CITY LIMITS?						13e. STREET AND NUMBER																							
Md.						Baltimore						Lutherville						YES <input type="checkbox"/> NO <input type="checkbox"/>						12 Nightengale Way																							
14 FATHER'S NAME						First						Middle						Last						15. MOTHER'S MAIDEN NAME						First						Middle						Last					
Henry Hennegan																								Anna ?																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown						(If yes give war or dates of service)						16b. SOCIAL SECURITY NO.						17 INFORMANT						Address																							
No.												217 32 7521						Dorothy L. Hennegan						Lutherville, Md.																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Abdominal carcinomatosis and																																															
1530 DUE TO, OR AS A CONSEQUENCE OF																																															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																																															
(b) Intestinal obstruction																																															
DUE TO, OR AS A CONSEQUENCE OF																																															
(c) Carcinoma of cecum																																															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																															
103																																															
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?						20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						Yes																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)						21b. TIME OF INJURY						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																			
						HOUR A.M. Month Day Year																																									
						P.M. 19																																									
21d. INJURY OCCURRED						21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)						21f. LOCATION						Street or R.F.D. No. City or Town County State																													
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>																																															
22a. I certify that (I) (this hospital) attended the deceased from 10/19, 1968, to 12/3, 1968, that (I) (we) last saw the deceased alive on 12/3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																															
22b. SIGNATURE																		DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED																	
																														12/3/68																	
22d. PHYSICIAN'S NAME (Type)																		22e. ADDRESS																													
Rudiger Breiteneker, M.D.																		6701 N. Charles Street																													
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION (City or Town) (County) (State)																													
Burial						Dec. 6, 68						Loudon						Baltimore, Baltimore, Md.																													
24. FUNERAL DIRECTOR																		ADDRESS						25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE																	
Wm. Cook-Brooks T wson, T wson, Md. 21204																								DEC 4 1968																							

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 5 & 6 Film 407		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		17089	
12/19/68 kk		12079		CERTIFICATE OF DEATH	
1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH
Frank		F.	Hertsch	12 Month 11 Day 68 Year	2b HOUR M
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	7 UNDER YEAR MONTHS
Male	White	May 7, 1895		73 YRS.	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
Richmond Va.	U.S.A.	Baltimore, Md			
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during last year)		12b. KIND OF BUSINESS OR INDUSTRY
Woodlawn Maryland	2021 Englewood Ave.		Retired Electrician		self emp
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
Maryland	Baltimore	Woodlawn	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2021 Englewood Ave.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		Address	
First Middle Last		First Middle Last			
Unknown		Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17 INFORMANT	
NO		218-14-8006		Frank F. Hertsch Jr. 2021 Englewood Ave.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Failure</u>					4 yrs
due TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u>					1963
Cofid tions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
443x					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 18</u> , 1965, to <u>Dec 11</u> , 1968 that (I) (we) last saw the deceased alive on <u>Dec 5</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>George E. Shannon M.D.</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED <u>Dec. 12, 1968</u>	
22d. PHYSICIAN'S NAME (Type) <u>Dr. George Shannon</u>				22e. ADDRESS <u>Medicial Arts Bulding</u>	
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Dec. 14, 68		Woodlawn Cemetery	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	
Loring Byers		8728 Liberty Rd.		DATE DEC 16 1968	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. This 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Items 7 & 8 File 1-108
12/31/68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 100 Film 7-108
12/1/68 11-11

1-020 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) CHARLES			First Middle Last HESS			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Dec. 15, 1968			2b HOUR 9:00 P. M.						
3 SEX male		4 RACE white		5 DATE OF BIRTH 71 YRS		6 AGE (In years last birthday) 71 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year December 15, 1968		2d HOUR 9:00 P. M.			
7a BIRTHPLACE (State or foreign country) Maryland			7b CIT ZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.						
10 CITY OR TOWN OF DEATH Baltimore				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Cntr.				12a USJAL OCCUPAT ON (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland				13b COUNTY Baltimore		13c CITY OR TOWN Lutherville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Rt 1 Box 4 4101 Granite Avenue			13f Jnifer		
14 FATHER'S NAME First Middle Last ?				15 MOTHER'S MAIDEN NAME First Middle Last ?											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO (If yes give war or dates of service) 212-32-34-1				17. INFORMANT Robert Wilson, 4101 Granite Ave.				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot Wound of Head DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDIT ON GIVEN IN PART 1 (a) 176 X															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR 8:30 P.M. 12/15/68				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) subj. shot self in head							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home				21f LOCATION Street or R.F.D. No City or Town County State Baltimore Co., Maryland							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opin on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>															
ACTUAL SIGNATURE Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED 12/16/68							
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
				ADDRESS (Street, city, town, or county)											
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b DATE 12/18/68				23c NAME OF CEMETERY OR CREMATORY Greenmount Cemetery				23d LOCATION (City or Town) (County) (State) Baltimore, Md.			
24 FUNERAL DIRECTOR Ulrich Funeral Home 4210 Belair Road.				ADDRESS				25. READ BY REGISTRAR DEC 20 1968				25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

<div style="display: flex; justify-content: space-between;"> 17091 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17091 </div>											
1 DECEASED-NAME (Type or print) Charles R. Hildenbrand				2a DATE OF DEATH December 11, 1968				2b. HOUR M			
3. SEX M		4 RACE W		5. DATE OF BIRTH 6-24-1883		6 AGE (In years last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Shenandoah, Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.					
1d CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chesapeake Manor N. H.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Signal Inspector		12b KIND OF BUSINESS OR INDUSTRY Pa. RR.					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE N. J.		13b COUNTY Point Pleasant		13c CITY OR TOWN Point Pleasant		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1327 Sleepy Hollow Rd.			
14 FATHER'S NAME First Middle Last Jacob F. Hildenbrand				15 MOTHER'S MAIDEN NAME First Middle Last Hannah D. Moyer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 17-05-6499		17 INFORMANT Address Road Charles F. Hildenbrand, 803 Ridgeleigh							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>8-10 weeks</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>331X</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/22</u> , 19 <u>68</u> , to <u>12/11</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/11</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Dr. A. Sedlack, M.D.</u>				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>12/13/68</u>			
22d. PHYSICIAN'S NAME (Type) Dr. Joseph A. Sedlack				22e. ADDRESS 200 W. Penna. Ave.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/14/68		23c. NAME OF CEMETERY OR CREMATORY Atlantic View		23d. LOCATION (City or Town) Manasquan		(County) N. J.		(State)	
24. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.				ADDRESS 4905 York Rd. Balto. 12, Md.		25a. DEC BY REGISTRAR DATE DEC 13 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

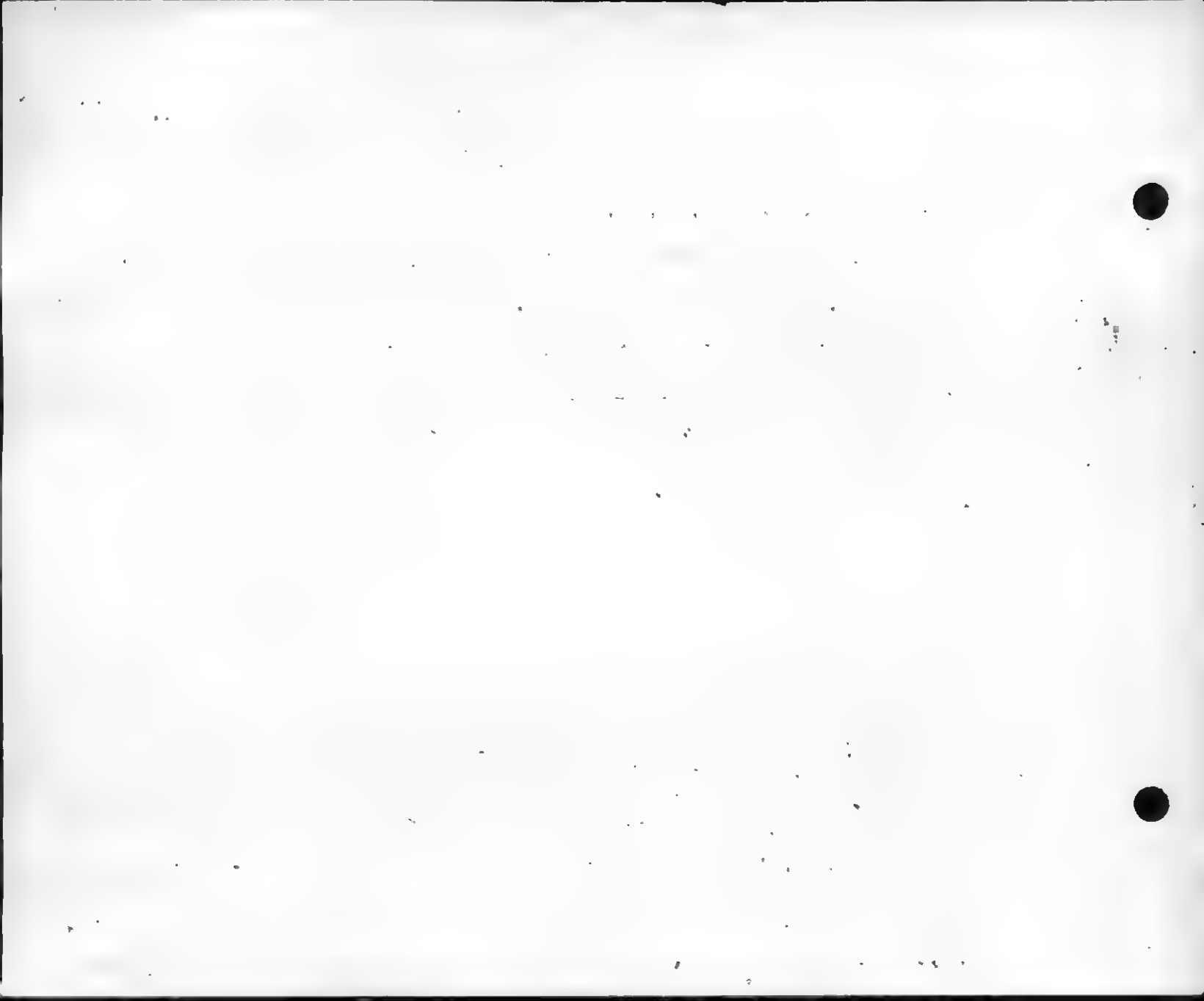
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1-68

17092
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17092

1. DECEASED NAME (Type or print) Otto F. Hoeflich			2a. DATE OF DEATH Month December Day 1 Year 1968			2b. HOUR 2:30 P.	
3. SEX M		4. RACE W		5. DATE OF BIRTH 7/19/1894		6. AGE (In years lost birthday) 74 YRS.	
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Baltimore 21212		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6632 Loch Hill Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired - Sheet Metal Work		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if first list on admission) STATE Md.		13b. CITY OR TOWN Baltimore Balto. 12.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6632 Loch Hill Road	
14. FATHER'S NAME First Middle Last George Jacob Hoeflich			15. MOTHER'S MAIDEN NAME First Middle Last Josephine Freckman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 216-09-4987		17. INFORMANT Address Miss Bertha Hoeflich (Same)			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED CARCINOMA 149X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) CARCINOMA OF THROAT DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 149X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from 3/6 , 1968, to 12/1 , 1968, that (1) (we) last saw the deceased alive on 11/26/68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death							
22b. SIGNATURE W. Meredith Smith M.D.		22c. DATE SIGNED 12/2/68		22d. PHYSICIAN'S NAME (Type) Dr. W. Meredith Smith			
22e. ADDRESS 6305 The Alameda							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/5/68		23c. NAME OF CEMETERY OR CREMATORY Baltimore		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.		25a. REC'D BY REGISTRAR DEC 2 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17098 CERTIFICATE OF DEATH 17093

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2 Burke Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> d. STREET ADDRESS <u>2 Burke Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Matthew Lawrence Holden</u> First Middle Last 4. DATE OF DEATH <u>December 25, 1968</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>May 14, 1921</u> 9. AGE (In years last birthday) <u>47</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Purchasing Agent</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Co., Md.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Matthew Lawrence Holden</u> 14. MOTHER'S MAIDEN NAME <u>Marion Flynn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u> 16. SOCIAL SECURITY NO. <u>218-12-4070</u> 17. INFORMANT <u>Walter Ball, Parkville, Md. 21234</u> Address <u>9010 Chateaugay Court,</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Upper Respiratory Infection</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>42</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>2 weeks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> , 19 <u>66</u> , to <u>Dec 23</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 23</u> 19 <u>68</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>Joseph A. Sedlacek</u> 22c. PHYSICIAN'S NAME (Type) <u>Joseph A. Sedlacek</u> 22d. ADDRESS <u>200 W. Penna. Ave., Towson, Md.</u> 22b. DATE SIGNED <u>12/25/68</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Dec. 27, 1968</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Catholic Cem.</u> 23d. LOCATION (City, town or county) (State) <u>Long Green, Balto. Co., Md.</u> 24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u> 25a. REC'D BY REGISTRAR <u>DEC 31 1968</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CONFIDENTIAL



FOR STATE
HEALTH DEPT.

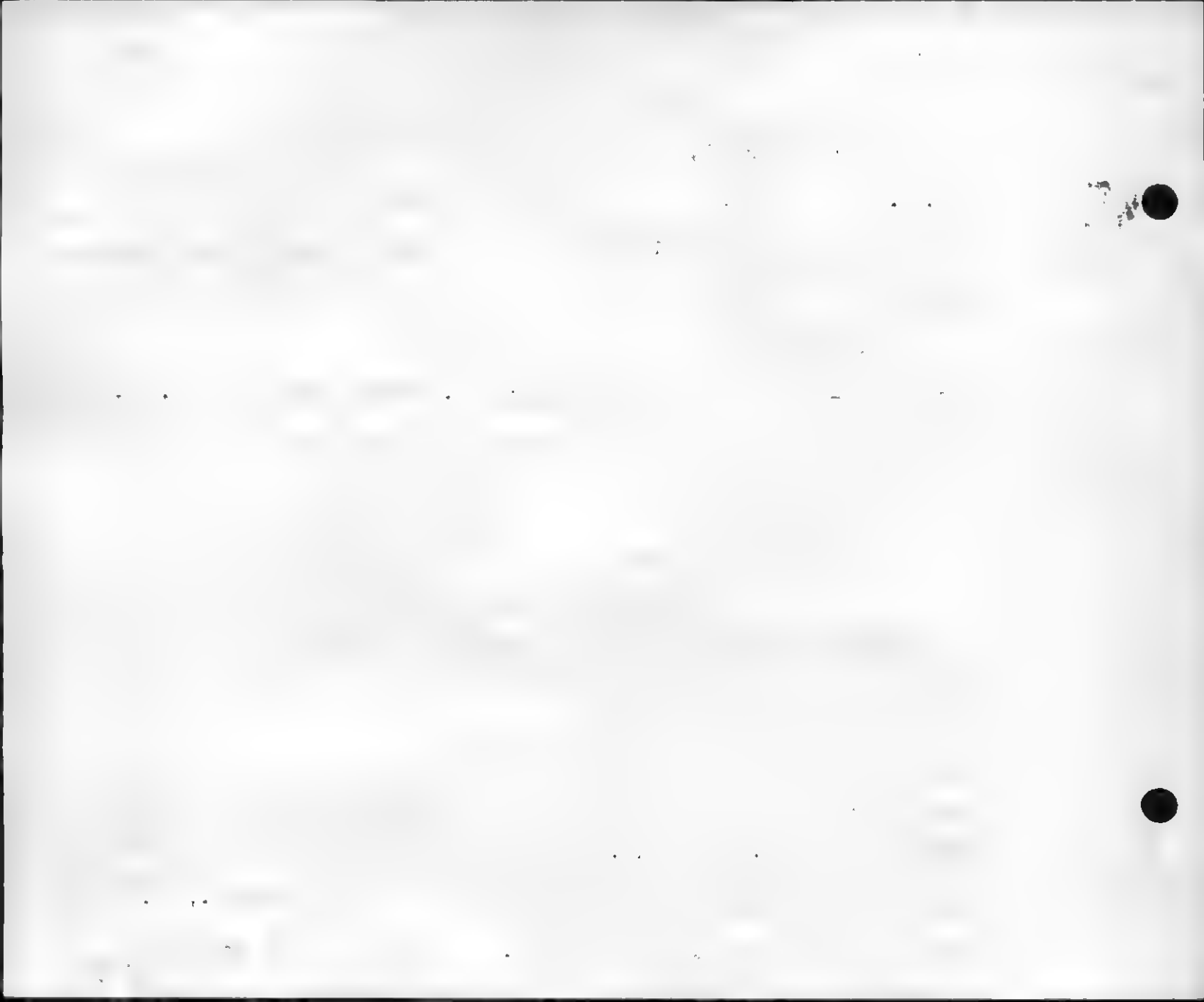
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17084

17094

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/> <input type="checkbox"/>			Month	Day	Year	2b. HOUR					
NELL PAULINE HUDSON											19	M					
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR						
female	white	March 1, 1914	34 YRS		MONTHS		DAYS		Month		Day	Year					
									December 23,		19	68					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH											
N. C.		USA				Baltimore		Md.									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY								
Middle River			1214 Third Road			Sewing Machine Operator			Clothing								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER								
Maryland			Baltimore		Middle River		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1214 Third Road								
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME														
First			Middle			Last			First			Middle			Last		
Robert McGuirt			Della Litaker														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT							ADDRESS				
No			237 01 1688			Curtis D. Hudson							1416 Wilson Pt. Rd. Balto 20				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>																	
DUE TO, OR AS A CONSEQUENCE OF (b)																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
4221																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?											
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
2. a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
			HOUR A.M. P.M. 19														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town			County		State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
Werner U. Spitz, M.D.															12/24/68		
ADDRESS (Street, city, town, or county)																	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)			(County)			(State)		
Burial			12/27/68			Oak Lawn Cemetery			Baltimore Co., Md.								
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REG. REGISTRAR'S SIGNATURE								
Brudzinski Funeral Home			1407 Eastern Ave.			DEC 27 1968			Charles Judge								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
17085		17085									
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
FRIEDA		A.		HUGHES				DEC Month 28 Day 1968 Year		10 P M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER YEAR MONTHS		IF UNDER 24 HRS HOURS MIN	
F		W		MAR, 7, 1900		68 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH					
MD		USA		NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTO.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
ESSEX		7503 RIDDLER AVE		HOUSE WIFE							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
MD.		BALTO.		ESSEX				7503 RIDDLER AVE			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
LEGEREE		HETZ		ANNA		EILTES					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address					
N/A				JOHN T. HUGHES SR.		ABOVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Pulmonary Emboli		Sudden					
1830		DUE TO, OR AS A CONSEQUENCE OF		Carcinomatosis		1 yr.					
(Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.)		DUE TO, OR AS A CONSEQUENCE OF		Carcinoma of ovary		?					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		City or Town		County		State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				MD							
22a. I certify that (I) (this hospital) attended the deceased from 1968, to 1968, that (I) (we) last saw the deceased alive on Dec 27 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE		22c. DATE SIGNED									
G.M. Baumgardner		12/20/68									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
G.M. BAUMGARDNER		Baltimore 21237									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
BURIAL		12/31/68		GARDEUS OF FAITH		BALTO. MD					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
J.E. CONNELLY SONS		300 MACE		DATE JAN 2 1969		Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17086

17096

1. DECEASED-NAME (Type or print) Nellie			First Middle Last			2a. DATE OF DEATH Month December Day 26 , Year 1968			2b. HOUR 4:30 ^A _M			
3 SEX Female			4. RACE White			5. DATE OF BIRTH June 3, 1899			6. AGE (In years last birthday) 69 YRS.			
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md			
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a. US.A. OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET AND NUMBER 414 Hollen Rd. 21212			14. FATHER'S NAME First Middle Last August Kullman			15. MOTHER'S MAIDEN NAME First Middle Last Fannie Colley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT E. Arthur Hurd, 414 Hollen Road,			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia 5621 DUE TO, OR AS A CONSEQUENCE OF (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.) (b) Ruptured Diverticulitis with Peritonitis DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) 572											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Dec. 24 , 19 68 , to Dec. 26 , 19 68 , that (I) (we) last saw the deceased alive on Dec. 26 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Eugenio Antonio, M.D.								22c. DATE SIGNED 12-26-68				
22d. PHYSICIAN'S NAME (Type) Eugenio Antonio, M.D.								22e. ADDRESS 7620 York Rd., Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 12/28/68			23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery			23d. LOCATION (City or Town) (County) (State) Parkville, Md.			
24. FUNERAL DIRECTOR Ulrich Funeral Home 4210 Belair Road.						25a. REC'D BY REGISTRAR DATE DEC 30 1968			25b. REGISTRAR'S SIGNATURE J. Charles Judge			

MEDICAL CERTIFICATION



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MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17087

17097

1. DECEASED NAME (Type or print) PRESTON A. HUTCHINSON			2a. DATE OF DEATH Month DEC. Day 29 Year 1968			2b. HOUR 11 A M				
3. SEX M		4. RACE W		5. DATE OF BIRTH AVE. 18, 1907			6. AGE (In years last birthday) 61 YRS			
7a. BIRTHPLACE (State or foreign country) VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO.				
10. CITY OR TOWN OF DEATH ESSEX			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 331 LORRAINE			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) TAVERN OWNER		12b. KIND OF BUSINESS OR INDUSTRY		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.			13b. COUNTY BALTO.		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 331 LORRAINE	
14. FATHER'S NAME First Middle Last QUINTON HUTCHINSON				15. MOTHER'S MAIDEN NAME First Middle Last CLIMERIA AMIDON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown UNK			16b. SOCIAL SECURITY NO. 217-03-6911		17. INFORMANT EVELYN HUTCHINSON			Address ABOVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory failure. 1612 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Extreme general weakness DUE TO, OR AS A CONSEQUENCE OF (c) Cancer of the Larynx								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 6 weeks. 2 years.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1612										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from October 10, 1955 , to December 23, 1968 , that (I) (we) last saw the deceased alive on December 23, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE Eugene C. Baumann DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 12-30-68				
22d. PHYSICIAN'S NAME (Type) Eugene C. Baumann						22e. ADDRESS 413 Eastern Ave. Baltimore 24 Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12/31/68		23c. NAME OF CEMETERY OR CREMATORY BELAIR		23d. LOCATION (City or Town) (County) (State) BELAIR MD.				
24. FUNERAL DIRECTOR J.B. CONNELLY SONS				ADDRESS 300 MACE		25a. REC'D BY REGISTRAR DATE JAN 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		



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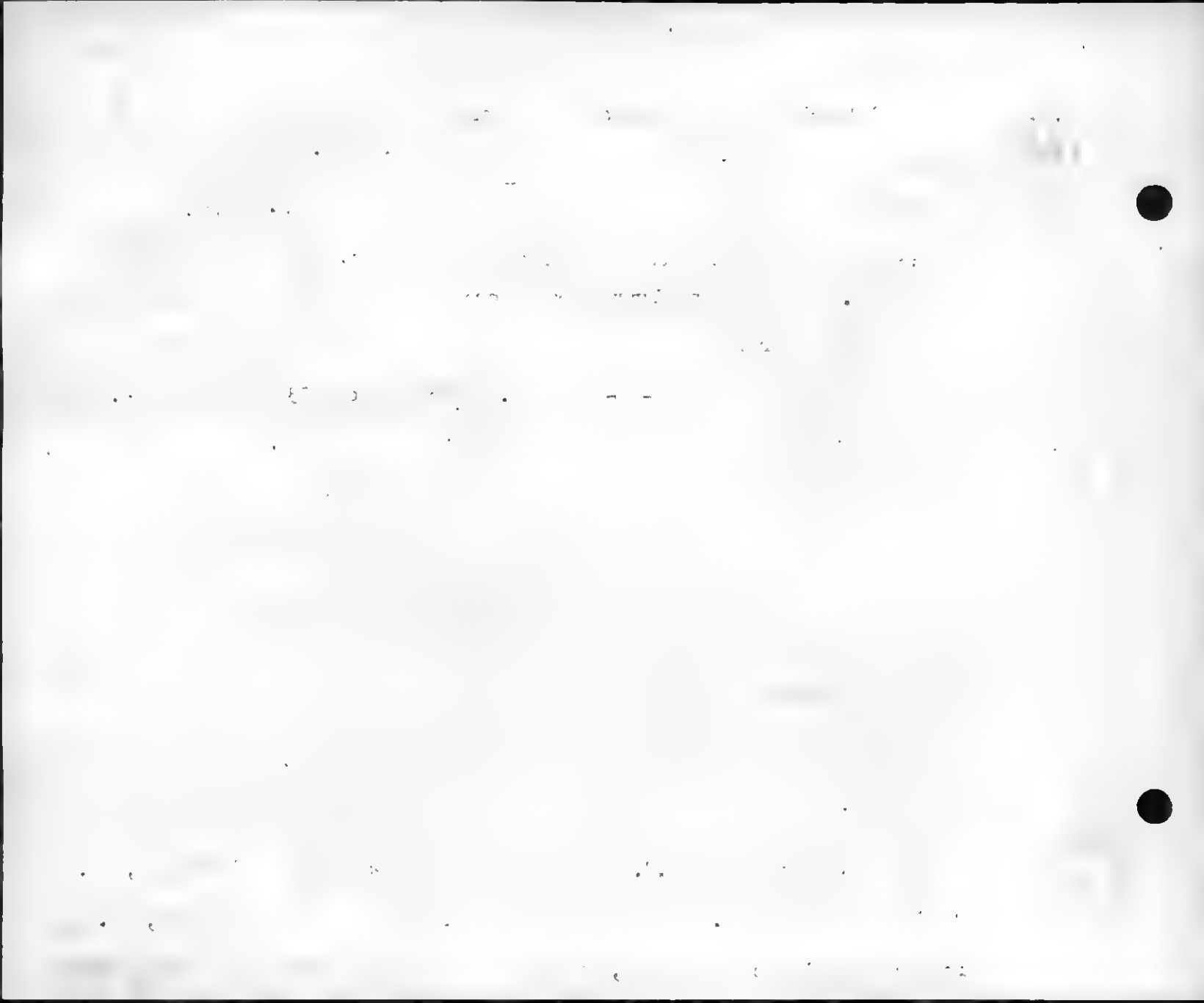
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

170988

17098

1 DECEASED-NAME (Type or print) Catherine Ceceila Hylock			2a DATE OF DEATH Month 12 Day 24 Year 68			2b HOUR M						
3 SEX Female		4 RACE White		5 DATE OF BIRTH October 25, 1914.		6 AGE (In years last birthday) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.						
10. CITY OR TOWN OF DEATH Towson			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St Joseph Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Tailor			12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3547 Woodring Ave			
14 FATHER'S NAME First Middle Last Emanuel Piraino				15. MOTHER'S MAIDEN NAME First Middle Last Josephine Messina								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)			16b SOCIAL SECURITY NO. 213-01-2197		17 INFORMANT Address Mr. Kenneth Hylock 3306 Bayonne Ave. #14							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Sebastian Russo						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 12/24/68			
22d. PHYSICIAN'S NAME (Type) Sebastian Russo M.D.						22e. ADDRESS 5017 Harford Rd Baltimore, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12/28/68.		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.				
24. FUNERAL DIRECTOR ADDRESS Leonard J Ruck Inc Baltimore, Maryland						25a REC'D BY REGISTRAR DATE DEC 26 1968			25b. REGISTRAR'S SIGNATURE J Charles Judge			



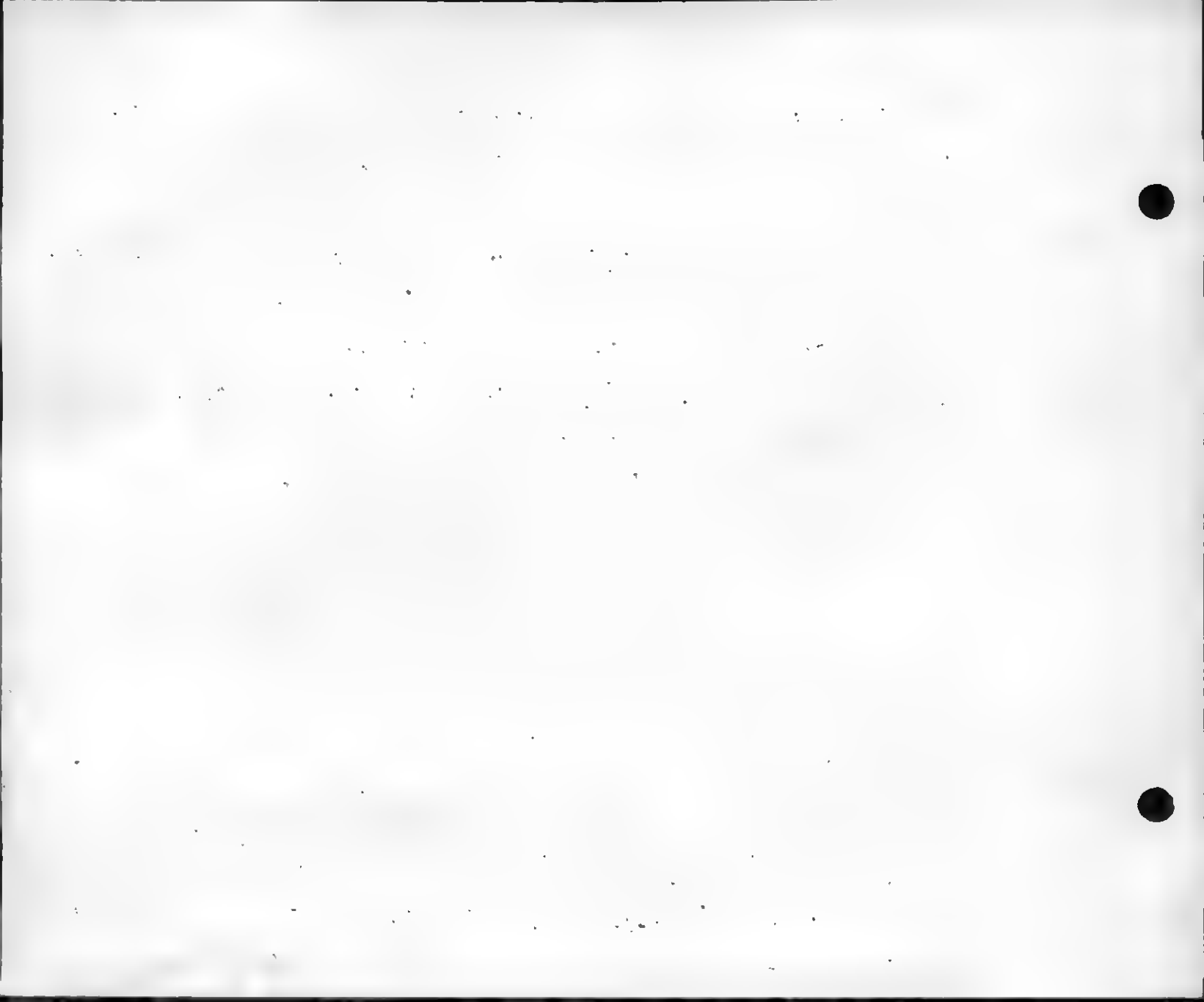
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VR A15
30M REV 1-68

17080										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17099									
1. DECEASED-NAME (Type or print) First Middle Last										2a. DATE OF DEATH Month Day Year										2b. HOUR M									
GIOVANNI D. IAMPIERI										DEC 30 1968																			
3 SEX M			4 RACE W			5 DATE OF BIRTH 4-28-1881			6 AGE (in years last birthday) 89 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN														
7a. BIRTHPLACE (State or foreign country) ITALY			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE						Md.														
10. CITY OR TOWN OF DEATH CATONSVILLE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RIDGEWAY MANOR			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) TAILOR			12b. KIND OF BUSINESS OR INDUSTRY CLOTHING																				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD			13b. COUNTY BALTIMORE			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 930 ST. AGNES LANE																	
14. FATHER'S NAME First Middle Last UNKNOWN IAMPIERI UNKNOWN			15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO 215-03-7997			17. INFORMANT WILLIAM IAMPIERI			Address 5706 EDMONDSON AVE																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4129 A.S.C.V.D.										years																			
DUE TO, OR AS A CONSEQUENCE OF (b) _____																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
4221																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from Jan 5 1968, to 12/30 1968, that (I) (we) last saw the deceased alive on 12/30 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE J. C. Pound			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 12/31/68																				
22d. PHYSICIAN'S NAME (Type) J. C. Pound			22e. ADDRESS 3325 Frederick Ave																										
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 1-2-69			23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEM			23d. LOCATION (City or Town) BALTIMORE (County) MARYLAND (State)																				
24. FUNERAL DIRECTOR			ADDRESS WEBER FUNERAL HOME 5311 EDMONDSON AVE			25a. REC'D BY REGISTRAR DATE JAN 3 1969			25b. REGISTRAR'S SIGNATURE J. Charles Judge																				

MEDICAL CERTIFICATION

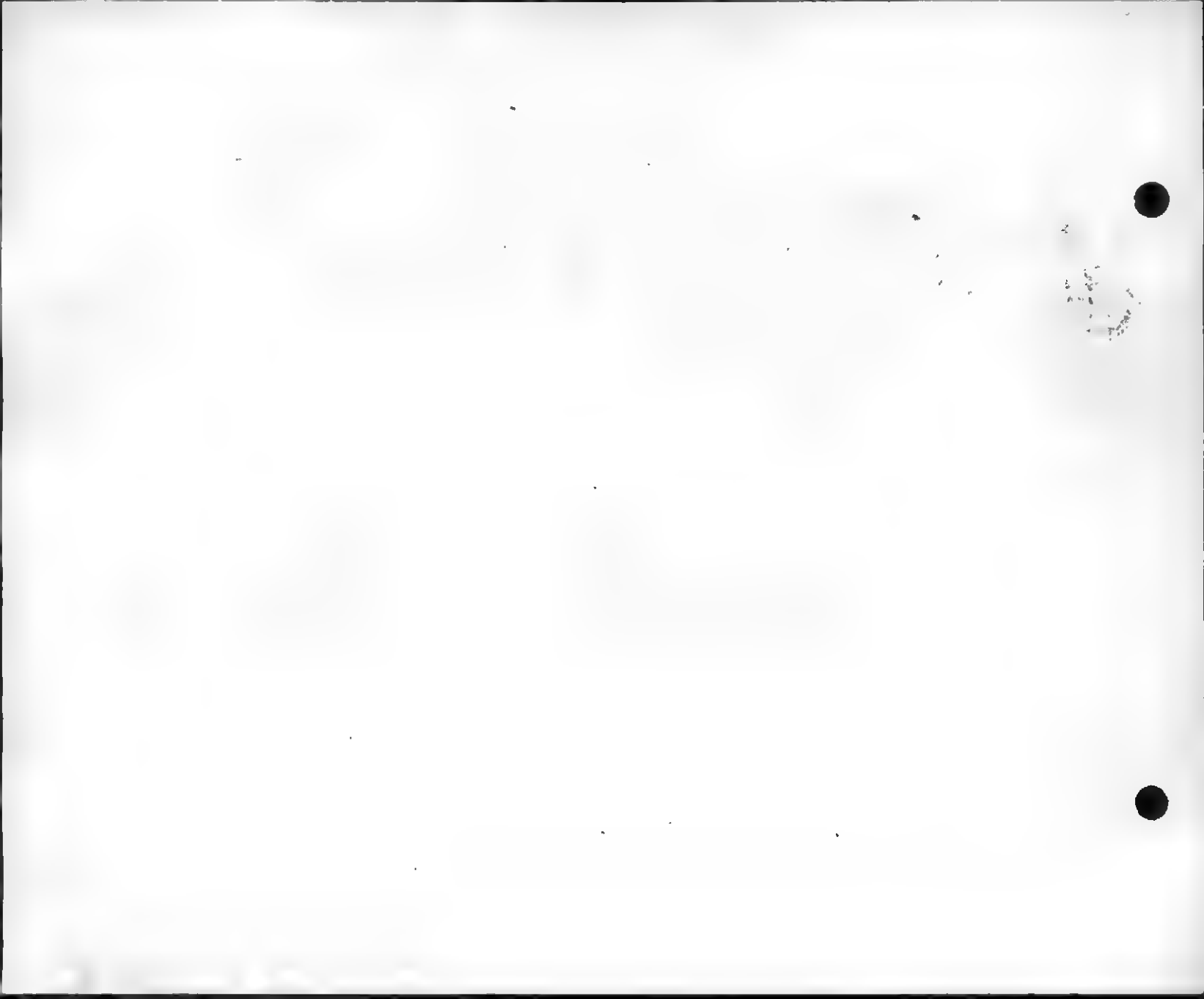


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VR A15 14
45M - 1/69

<div> <div>Items 7 & 8 Film 403</div> <div>12/31/68 kk</div> <div>17000</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>17100</div> </div>										
1. DECEASED-NAME (Type or print) JAMES JACKSON					2a. DATE OF DEATH 12 Month 4 Day 68 Year		2b. HOUR 11:28 AM			
3. SEX Male		4. RACE Colored		5. DATE OF BIRTH		6. AGE (In years last birthday) 59 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTH-PLACE (State or foreign country) unknown		7b. CITIZEN OF WHAT COUNTRY? unknown		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore				
10. CITY OR TOWN OF DEATH GARRISON, MD			11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tal give street address) FOXLEIGH Nursing Home			12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD			13b. COUNTY Balto		13c. CITY OR TOWN Balto		13d. INSIDE - CITY LIM 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1722 Division Street	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction										
DUE TO, OR AS A CONSEQUENCE OF (b) Blunt force trauma										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Dec 3 , 19 68 , to Dec 4 , 19 68 , that (I) (we) last saw the deceased alive on Dec 3 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Vicente D. Ayala		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED Dec 4-68				
22d. PHYSICIAN'S NAME (Type) VICENTE D AYALA		22e. ADDRESS Spring Green St Baltimore								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12.12.68		23c. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School		23d. LOCATION (City or Town) Baltimore, Md.		(County) (State)		
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE DEC 20 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



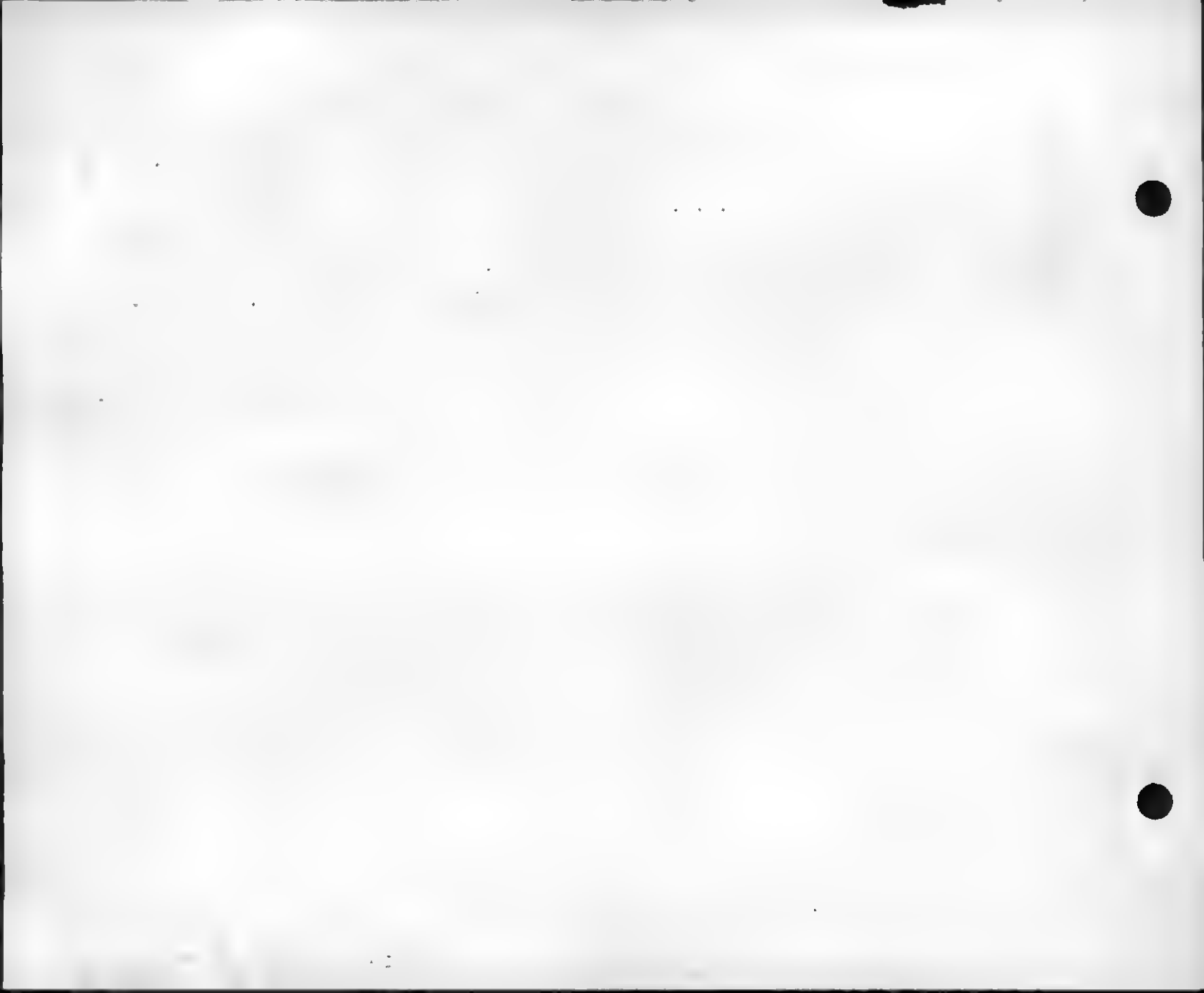
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR 7:10 AM	
William		Edgar	JACOBS	12 23 68					
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthdy)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
Male	White		2/21/52		16 yrs. 10 yrs. 10 mo.				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Washington	U.S.A.				Baltimore Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Owings Mills		Rosewood State			none		---		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Frederick		Frederick				212 N. Market St.	
14. FATHER'S NAME			15. MOTHER'S M.A.DEN NAME						
First Middle Last			First Middle Last						
William Edgar JACOBS			Julia Lucretia SCHAEFFER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT Address					
No		---		Rosewood Records, Owings Mills, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Bronchial obstruction</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ruptured Pulmonary Abscess</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sever Mental Retardation, institutionalized 12 yrs.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPTSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)									
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)									
21f. LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>2/20/56</u> , 19 <u>56</u> , to <u>2/23/68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/23/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Richard L. Jones</u> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>									
22c. DATE SIGNED <u>24 Dec 68</u>									
22d. PHYSICIAN'S NAME (Type)									
22e. ADDRESS									
23a. BURIAL CREMATION, REMOVAL (Specify)									
23b. DATE <u>12/27/68</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>Park Heights</u>									
23d. LOCATION (City or Town) (County) (State) <u>Brunswick-Fred. Md</u>									
24. FUNERAL DIRECTOR ADDRESS									
<u>Leete Funeral Home Brunswick-Md.</u>									
25a. REC'D BY REG. STRAR DATE <u>DEC 31 1968</u>									
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>									

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

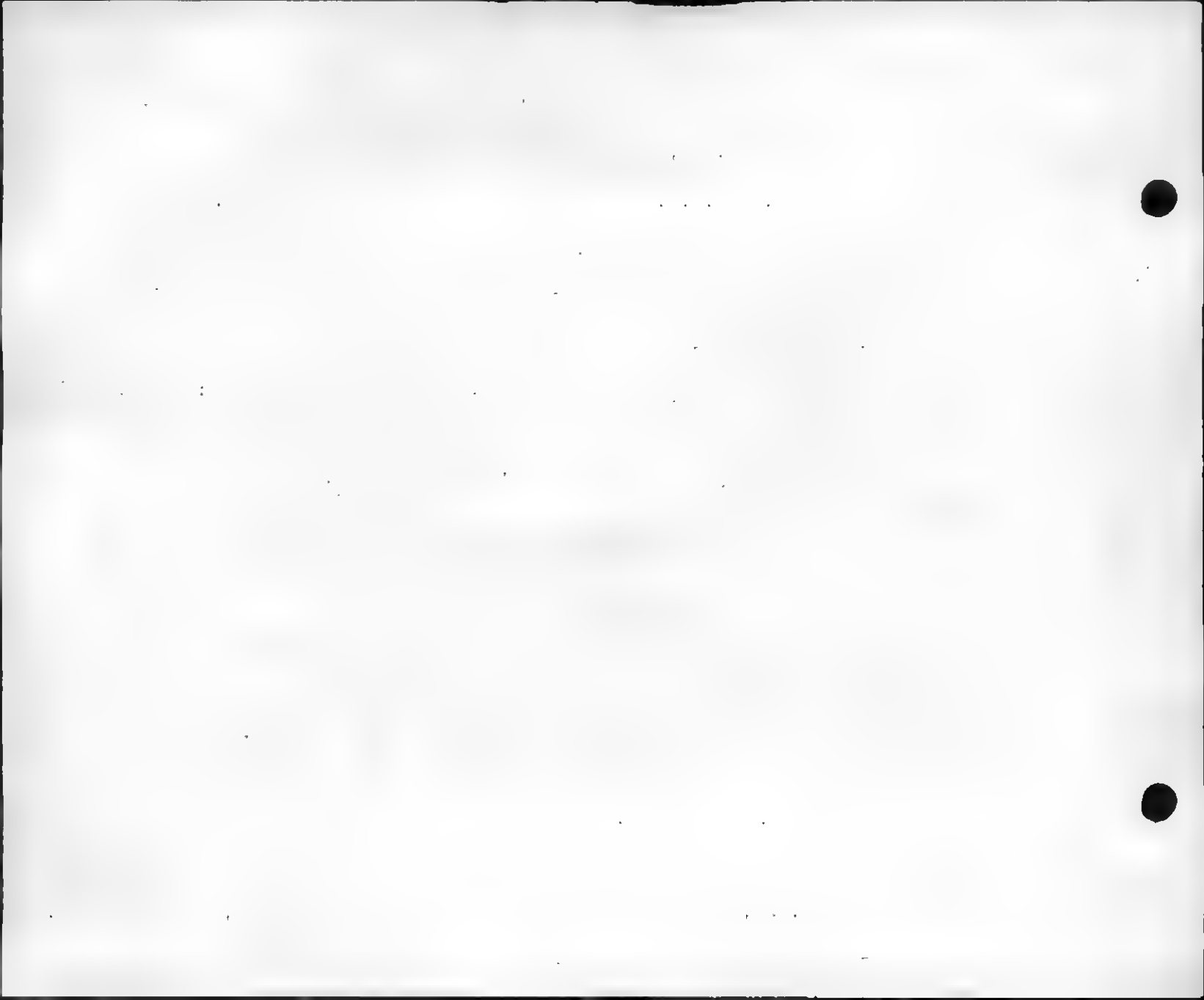
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1013. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17102

1. DECEASED NAME (Type or Print) John Ward Jeffries			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 12-19-68			2b. HOUR M		
3. SEX M	4. RACE Cauc.	5. DATE OF BIRTH Aug. 27, 1896	6. AGE 72 YRS	IF UNDER 1 YEAR MONTHS DAYS 	IF UNDER 24 HRS HOURS MIN 	2c. DATE PRONOUNCED DEAD Month Day Year 19		
7a. BIRTHPLACE (State or foreign country) Baltimore Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md		
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address) St. Joseph			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Martin Aircraft		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md		13b. COUNTY Baltimore		13c. CITY OR TOWN Pheonix		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 14 Dalebrook Dr.
14. FATHER'S NAME T. Lucien Jeffries				15. MOTHER'S MAIDEN NAME Elizabeth Ward				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 212 22 3744		17. INFORMANT ADDRESS Mrs. Mildred Peregoy, Pheonix, Md. 21131				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Chronic Emphysema DUE TO, OR AS A CONSEQUENCE OF 10+ yrs. (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No City or Town County State 				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Charles F. O'Donnell				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 12/20/68		
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
				ADDRESS (Street, city, town, or county) 				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 20, 68		23c. NAME OF CEMETERY OR CREMATORY Loudon		23d. LOCAT ON (City or Town) Baltimore, Baltimore, Md.		(County) (State)
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md.				ADDRESS 		25a. REC'D BY REGISTRAR DEC 23 1968		25b. REGISTRAR'S SIGNATURE Charles F. O'Donnell



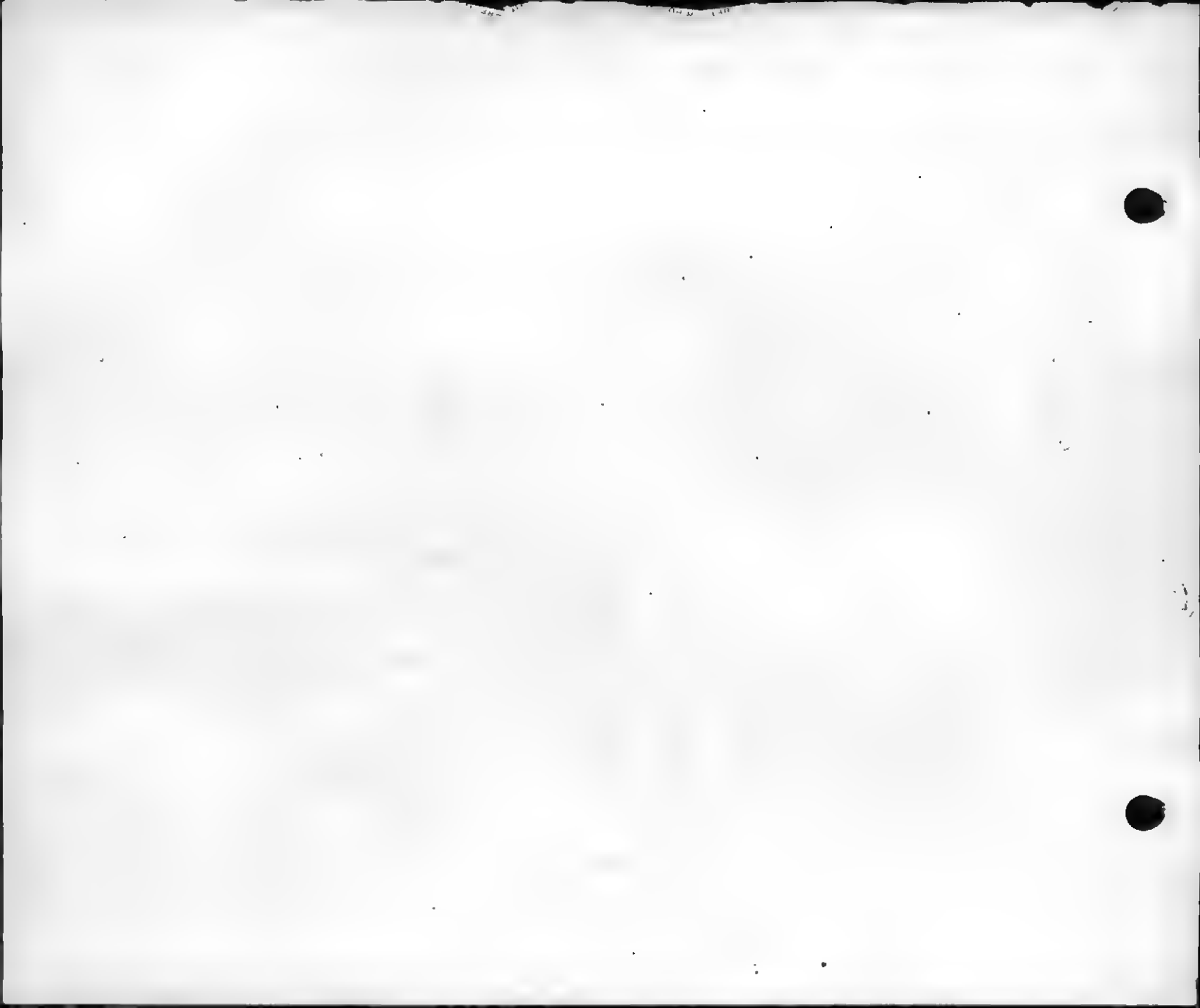
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17093 CERTIFICATE OF DEATH 17103

1. PLACE OF DEATH a. COUNTY <i>Baltimore Co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Hartford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Phie Fears Rd</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Talston md</i>	
c. LENGTH OF STAY IN 1b <i>2 yr</i>		d. STREET ADDRESS <i>Records Rd</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Bradshaw bid</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>CLARENCE E</i> Middle <i>JOHNSON</i> Last <i>JOHNSON</i>		4. DATE OF DEATH Month <i>12</i> Day <i>16</i> Year <i>1968</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>OCT 17 1902</i>
9. AGE (In years last birthday) <i>66</i> yrs.		10. IF UNDER 1 YEAR: Months <i>66</i> Days <i>66</i> Hours <i>66</i> Min. <i>66</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Hartford Co</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>JACOB H JOHNSON</i>	
14. MOTHER'S MAIDEN NAME <i>NELLIE MATHEWS</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>YES 4-17-41-31-44</i>	
16. SOCIAL SECURITY NO. <i>216-18-4940</i>		17. INFORMANT <i>George Johnson</i> Address <i>Bradshaw bid</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO (b) <i>Myocarditis & hypertension</i> DUE TO (c) <i>Diabetes mellitus</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>25 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>8-27</i> , 19 <i>67</i> , to <i>12-16</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12-15</i> , 19 <i>68</i> , and that death occurred at <i>6 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Fred O. Hodous</i>		22b. DATE SIGNED <i>12-16-68</i>	
22c. PHYSICIAN'S NAME (Type) <i>Fred O. Hodous</i>		22d. ADDRESS <i>Edgewood Pnd</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>12-14-68</i>	23b. DATE THEREOF <i>12-14-68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Talston-Hartford</i>	23d. LOCATION (City, town or county) (State) <i>Talston Hartford md</i>
24. FUNERAL DIRECTOR <i>George W Tittle Bel Air md</i>		25a. REC'D BY REGISTRAR <i>DEC 17 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

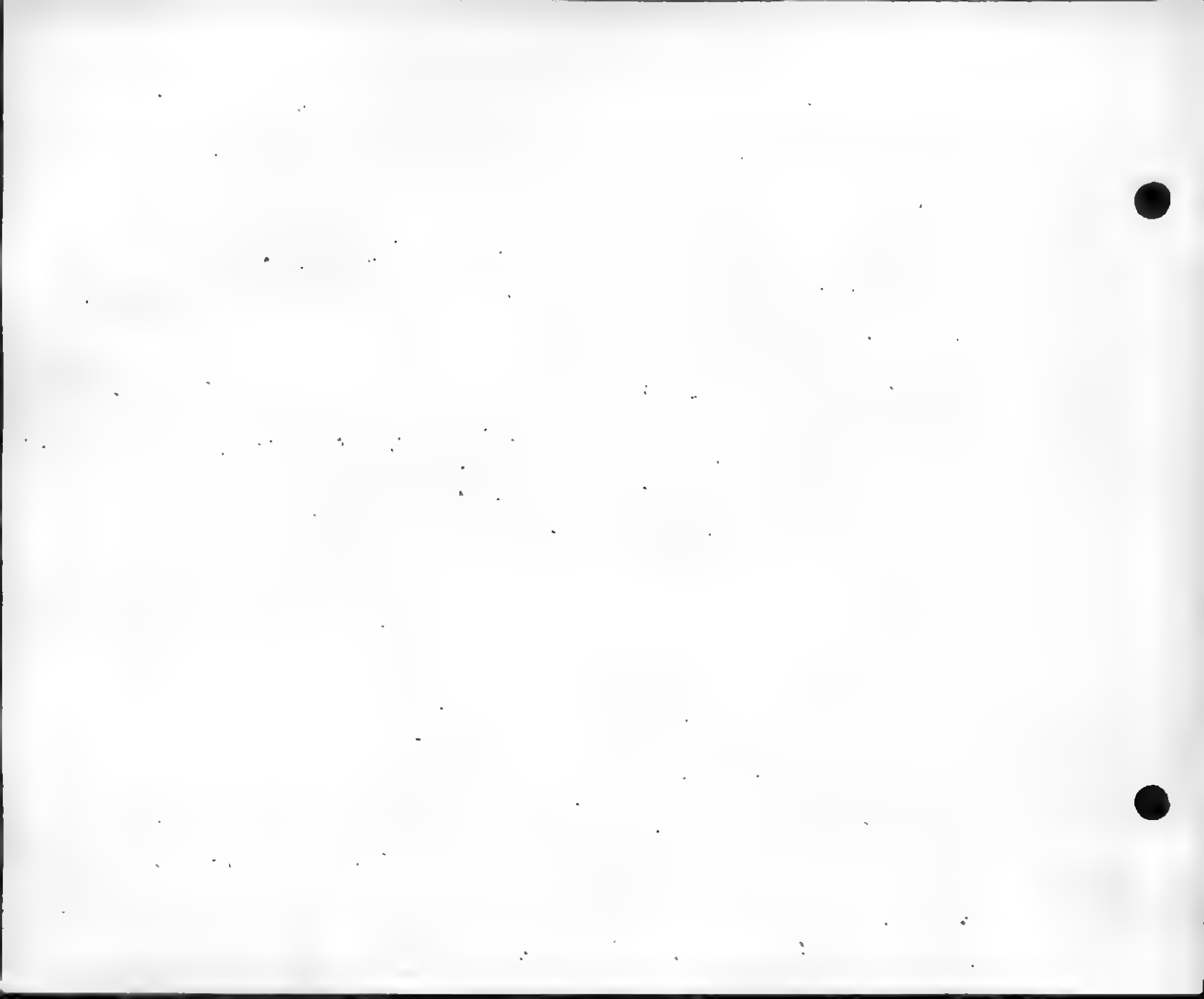


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print) BERTHA			First BERTHA Middle JONES Last JONES			2a DATE OF DEATH 12 Month 29 Day 1968 Year			2b. HOUR M			
3. SEX F		4. RACE W		5 DATE OF BIRTH 1-6-1893			6. AGE (in years last birthday) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.						
10 CITY OR TOWN OF DEATH Balto.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1618 Elligson Rd			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Homemaker			
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MD			13b COUNTY Balto.		13c CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 2919 Hait Ave.			
14 FATHER'S NAME First Christian R. Middle Baesch Last Baesch				15. MOTHER'S MAIDEN NAME First Samuel Jones Middle 1618 Elligson Rd. Last								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO (If yes give war or dates of service) 215-22-9926		17. INDEORMANT Address Samuel Jones 1618 Elligson Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 12-29-68												
DUE TO, OR AS A CONSEQUENCE OF												
(b) ACUTE MYOCARDIAL FAILURE 12-9-68												
DUE TO, OR AS A CONSEQUENCE OF												
(c) HYPERTENSIVE ARTERIOSCLEROTIC C.V DISEASE 7-7-65												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) NONE												
19a. DATE OF OPERATION NONE			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NONE			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) NONE			21b TIME OF INJURY HOUR A.M. Month Day Year NONE			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) NONE						
21d INJURY OCCURRED While <input type="checkbox"/> Mahyle <input checked="" type="checkbox"/> at work or work NONE			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) NONE			21f. LOCATION Street or R.F.D. No. City or Town County State NONE						
22a. I certify that (I) (this hospital) attended the deceased from 7-7-65 to 12-29-1968 , that (I) (we) last saw the deceased alive on 12-24-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE Samuel A. Schimunek MD						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED 12-30-68			
22d. PHYSICIAN'S NAME (Type) SAMUEL A. SCHIMUNEK MD						22e ADDRESS 842 S. EAST AVE 31224						
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 1-2-1969		23c. NAME OF CEMETERY OR CREMATORY Parkwood			23d. LOCATION (City or Town) (County) (State) Balto. Md.				
24. FUNERAL DIRECTOR Thelma A. Hoffmann						ADDRESS 3218 Hudson St.			25a. REC'D BY REGISTRAR DATE JAN 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

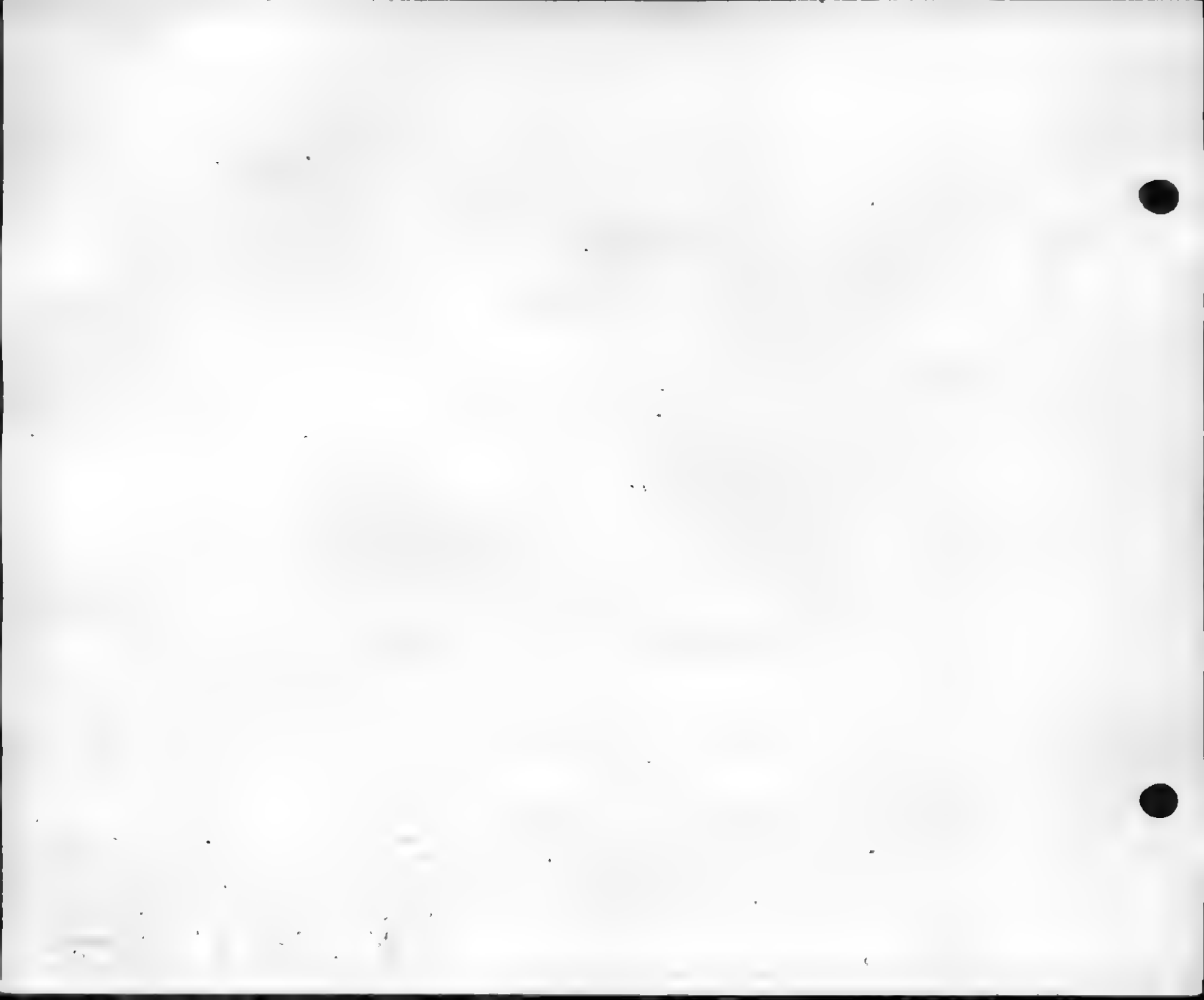
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17095

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17105

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
CLAUDE				JONES	December 21, 1968		12	57	PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR	F. UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR
M	C	8/17/06		62 YRS	MONTHS	DAYS	HOURS	MIN	December 21, 1968	12 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Virginia		U S A				Baltimore				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		St. Joseph		Retired		Construct				
13a. U.S.A. RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b. CO. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md.		Pasadena		Pasadena		YES <input type="checkbox"/> NO <input type="checkbox"/>		Route 9		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Frank Jones					Ida Moore					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
no		217-01-3459		Mrs Lector Jones,		Same				
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Metastatic Carcinoma of Lung		217-01-3459		Mrs Lector Jones,		Same		6 Months		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		(c)				1 yr		
(b) Carcinoma of Stomach										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
151X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		Hour A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Charles F. O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED
EXAMINER'S NAME (Type)		Charles F. O'Donnell, M.D.		ADDRESS (Street, city, town, or county)						12/21/68
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial		12/29/68		Mt. Calvary Cemetery		A A		County		Md.
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
I Carroll,		Halstead Funeral Home		DEC 23 1968		Charles Judge				
		1206 W North Ave								



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

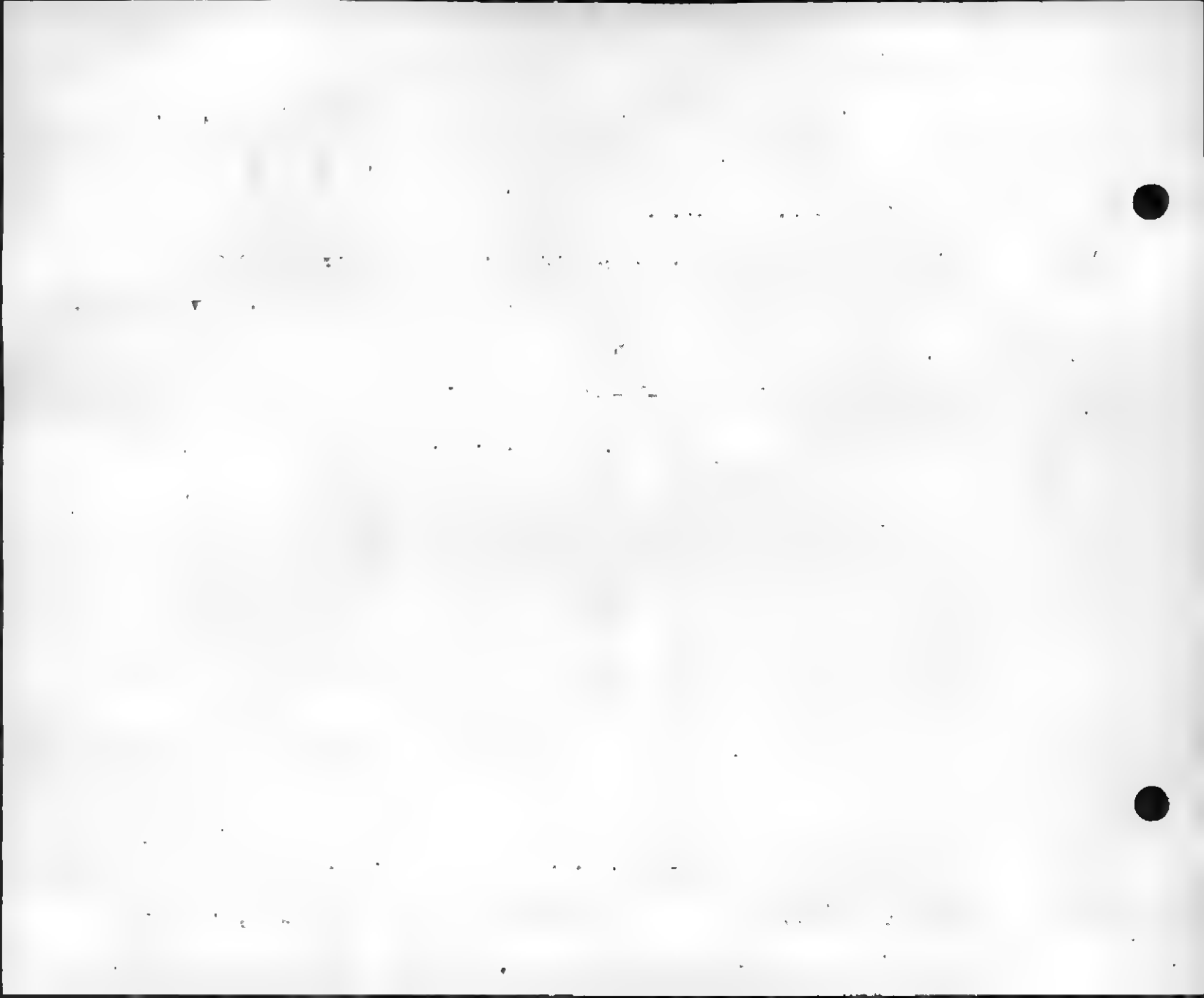
17096

17106

1. DECEASED-NAME (Type or print) First Middle Last HARRY FRANCIS KANE			2a. DATE OF DEATH Month Day Year December 5, 1968		2b. HOUR 4:55 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH October 22, 1909		6. AGE (In years last birthday) 58 59 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Doctor Physician		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 913 E. Belvedere Ave.	
14. FATHER'S NAME First Middle Last Kane			15. MOTHER'S MAIDEN NAME First Middle Last Mrs Marie E Kane		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) Yes WW 11		16b. SOCIAL SECURITY NO 261-12-3454		17. INFORMANT Address Mrs Marie E Kane Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon with metastasis 1558 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (X) (this hospital) attended the deceased from 12/2/ 19 68 , to 12/5/ 19 68 , that (X) (we) last saw the deceased alive on 12/5/ 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Lawrence F. Misanik, M.D.				22c. DATE SIGNED 12/6/68	
22d. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.		22e. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/7/68	23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR L. J. Beck, Inc.		ADDRESS Balto, Md		25a. REC'D BY REGISTRAR DEC 6 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First ALFRED			Middle ALBERT			Last KEEFER			2a. DATE OF DEATH Month DECEMBER Day 28, 1968 Year			2b. HOUR 12:30 P.M.		
3 SEX MALE			4 RACE WHITE			5 DATE OF BIRTH 10/17/1919			6 AGE (in years last birthday) 48 49 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8- MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE			Md					
10. CITY OR TOWN OF DEATH BALTO. TOWSON 4			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) STEELWORKER			12b. KIND OF BUSINESS OR INDUSTRY BETH. STEEL								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND 21234			13b. COUNTY BALTIMORE			13c. CITY OR TOWN			3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 1746 WHITE OAK ROAD					
14. FATHER'S NAME First Albin B.			Middle Keefe			Last Keefe			15. MOTHER'S MAIDEN NAME First Veronica			Middle Abbott Last Abbott					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) yes			(If yes give war or dates of service) WWII			16b. SOCIAL SECURITY NO 176 16 9697			17. INFORMANT family records			Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra Cerebral Hemorrhage Right</u> <u>4120</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>443X</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTE <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home farm street factory office building etc)			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 21</u> , 19 <u>68</u> , to <u>Dec. 28</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec. 28</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Christine Feliciano M.D.</u>			DEGREE M.D.			ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED DEC. 28, 1968								
22d. PHYSICIAN'S NAME (Type) Christine Feliciano M.D.			22e. ADDRESS 7620 York Road, Towson 4, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE 12/31/68			23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk			23d. LOCATION (City or Town) (County) (State) Balto. County, Md/								
24. FUNERAL DIRECTOR C. F. EVANS & SON 8802 Harford Road			ADDRESS			25a. REC'D BY REGISTRAR DATE DEC 31 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>								

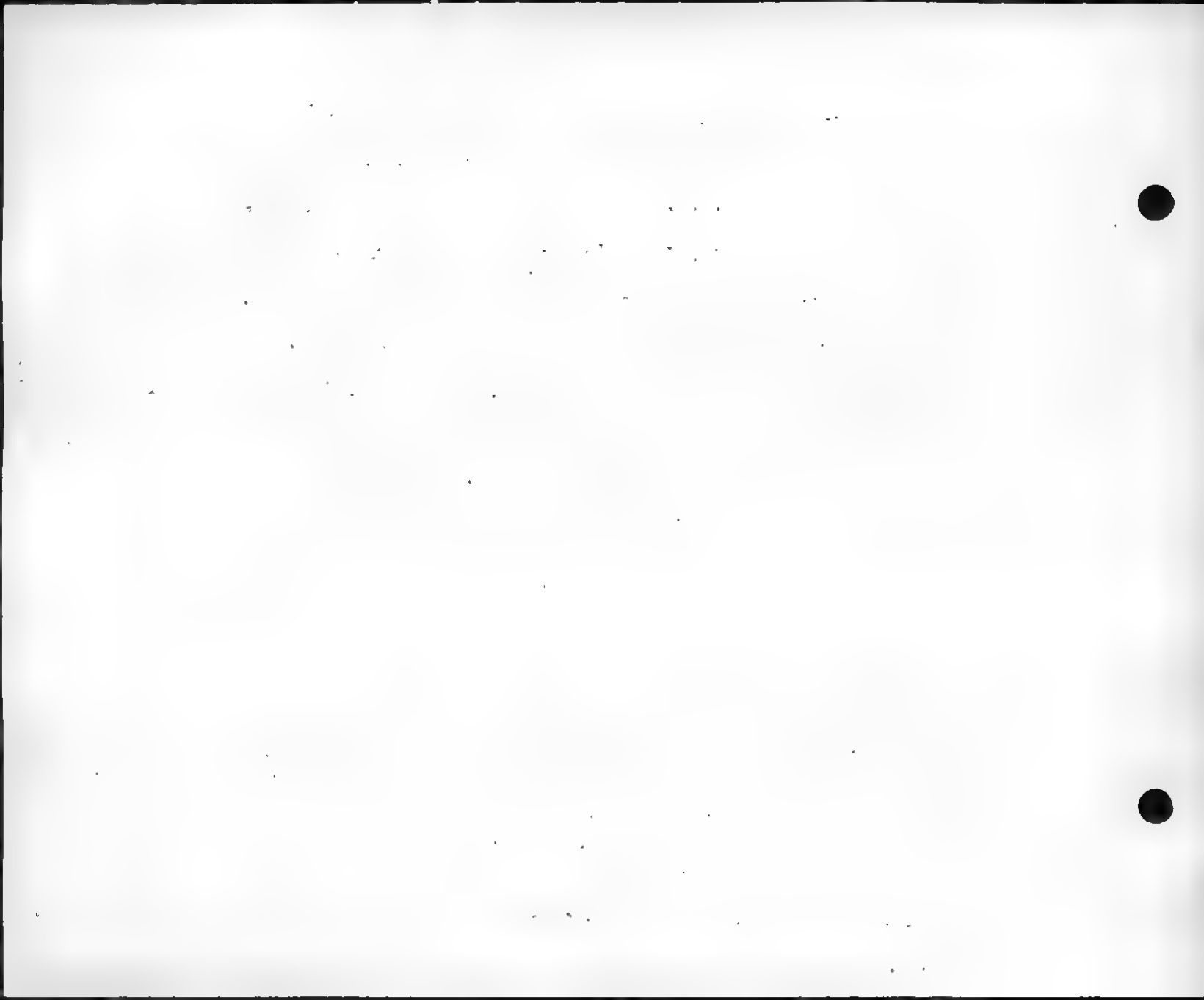
17107



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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17098										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17108																			
1										CERTIFICATE OF DEATH																													
1. DECEASED-NAME (Type or print) First Middle Last HENRY M. KELLY										2a. DATE OF DEATH DEC Month 27 Day 1967 Year										2b. HOUR 4.30 M																			
3 SEX M					4 RACE W					5 DATE OF BIRTH March 6, 1879										6 AGE (In years last birthday) 89 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS HOURS MIN									
7a. BIRTHPLACE (State or foreign country) Virginia					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9 COUNTY OF DEATH Baltimore Md.																								
10. CITY OR TOWN OF DEATH Catonsville					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Nursing Home					12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Retired Plumber					12b. KIND OF BUSINESS OR INDUSTRY																								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland					13b. COUNTY Baltimore					13c. CITY OR TOWN Catonsville					3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 1351 N. Rolling Road																			
14. FATHER'S NAME First Middle Last Bartholmew Kelly										15. MOTHER'S MAIDEN NAME First Middle Last Ellen Harding										21228																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No										16b. SOCIAL SECURITY NO.					17 INFORMANT Mrs. Kathleen F. Storey, 10 Montrose Manor Ct										Address 21228														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 486X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 2 weeks																								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 71228																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>1 June</u> , 19 <u>67</u> , to <u>12/27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/26</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE <u>Wm. J. Jordan</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>																				22c. DATE SIGNED 12/27/68																			
22d. PHYSICIAN'S NAME (Type) <u>William J. Jordan MD</u>																				22e. ADDRESS 1335 Sulphur Lane St-21227																			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b. DATE 12-31-1968										23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery										23d. LOCAT ON (City or Town) (County) (State) Baltimore, Maryland									
24 FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue										ADDRESS 21229										25a. REC'D BY REGISTRAR DATE DEC 30 1968										25b. REGISTRAR'S SIGNATURE J. Charles Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

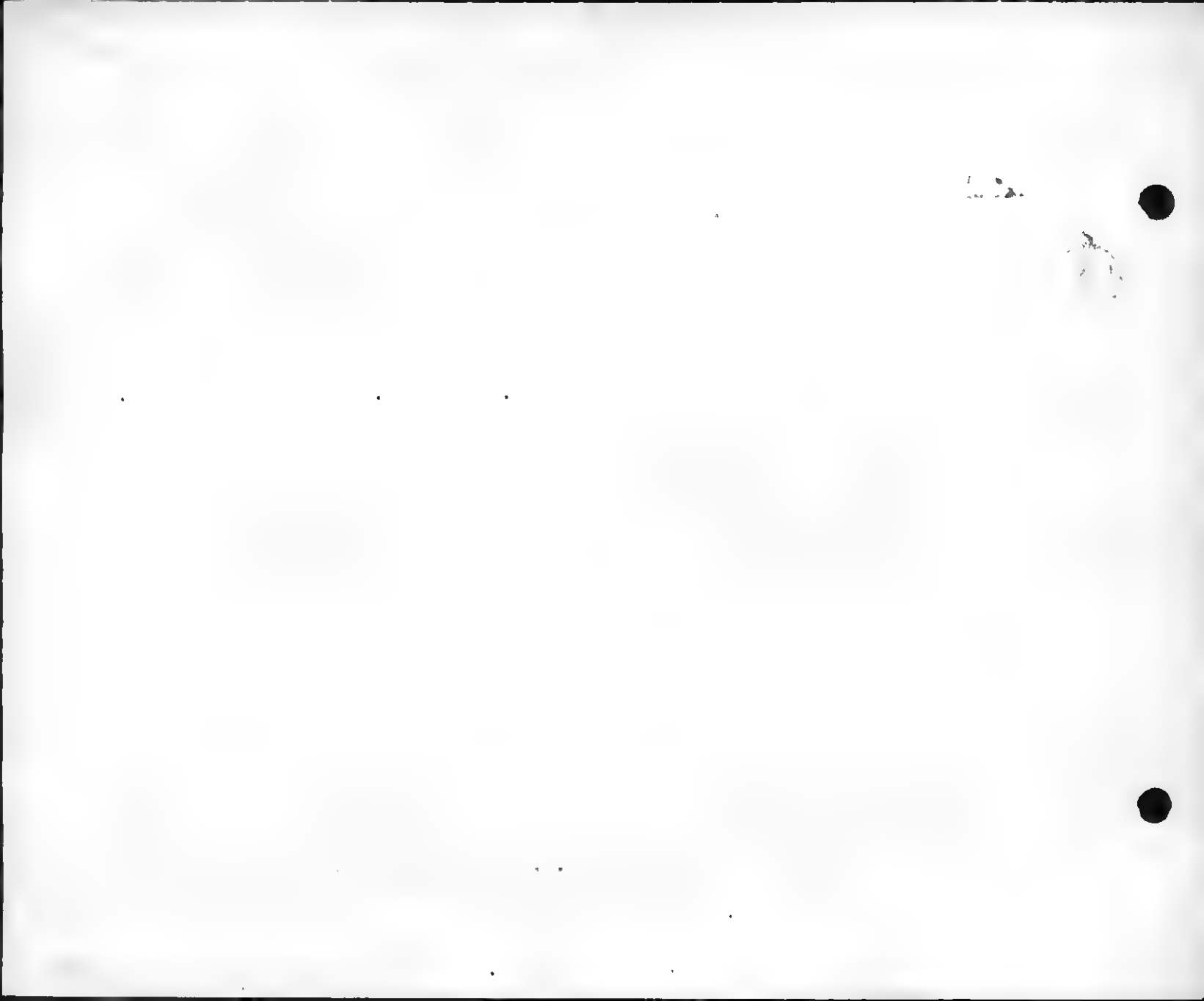
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health or for burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17109

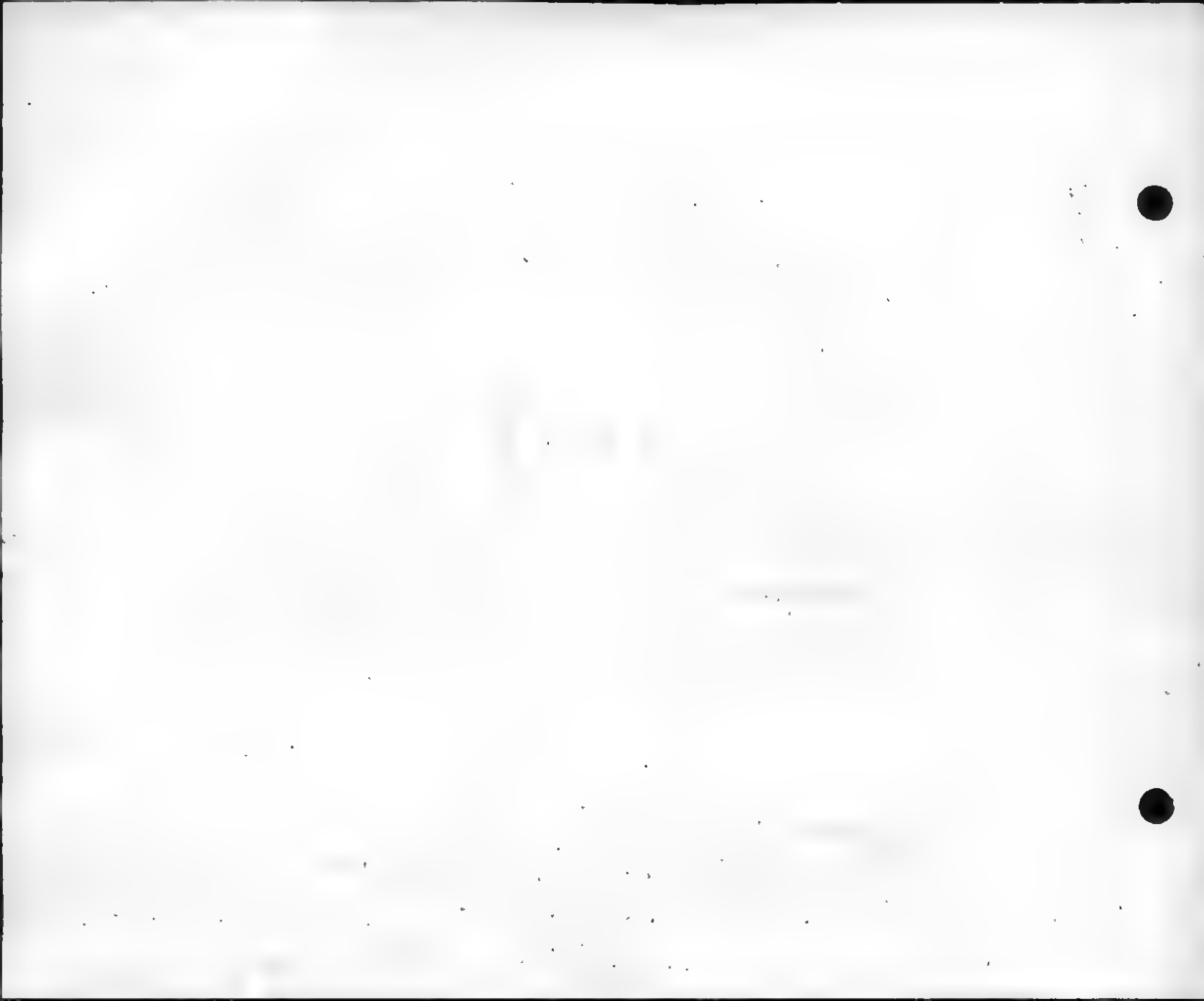
1. DECEASED-NAME (Type or print) Virginia R ice KELLY			2a. DATE OF DEATH Month 12 Day 16 Year 1968		2b. HOUR 11:25 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH 8-15-1894		6. AGE (in years last birthday) 74 YRS	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS HOURS MIN
7a. BIRTH-PLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore		Md
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1711-D Waverly Way	
14. FATHER'S NAME First Middle Last Anthony P. Rice			15. MOTHER'S MAIDEN NAME First Middle Last Mary Schmidt		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 217-48-6099		17. INFORMANT Kelly Address Mr. Robert J. Kelly 1963 White Oak Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Terminal carcinomatosis, primary in colon 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 1538 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Acute gastric dilatation					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (1) (this hospital) attended the deceased from 12/16/ 19 68 , to 12/16/ 19 68 , that 10 (we) last saw the deceased alive on 12/16/ 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (d'd) (did not) view the body after death.					
22b. SIGNATURE Reynaldo Orjuela-Gomez, M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/16/68	
22d. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.		22e. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/19/68	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR John A. Moran, Inc. 3000 C. Baltimore St.		25a. RECEIVED BY REGISTRAR DEC 20 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)			First Middle Last			20. DATE OF DEATH Month Day Year			2b. HOUR 2 15 P.M.					
Helen Chilton Kenyon						Dec. 26 68								
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Female		White		3-3-1876			92 YRS.		2 12		12 15			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md		
Maryland			U.S.A.						Baltimore					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore County			Hosch Maus & Lebowitz Home											
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
674 E. 41st St.			13b. COUNTY			Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		604 E. 41st St.				
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last											
Colin Chilton			Belle Betty											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO (If yes give war or dates of service)			17. INFORMANT Name Address								
						Frances Shuckler 615 Chestnut Ave.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ASCVD.</u> 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 Influenza														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Nov. 16, 1954, to Dec. 26, 1968, that (I) (we) last saw the deceased alive on Dec. 26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Newland E. Day MD						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED December 29, 1968					
22d. PHYSICIAN'S NAME (Type) Newland E. Day, M.D.						22e. ADDRESS 4-E-33rd St Balto Md								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial			12-30-68		Moriatto Church Cemetery			Kilmarnock Virginia						
24. FUNERAL DIRECTOR ADDRESS Wm Cook-Brooks Towson Inc 1050 York Rd Towson, Md. 21204						25a. REC'D BY REGISTRAR DATE DEC 30 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge						



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 4 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME [5]
10M REV. 1/68

17101

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17111

1. DECEASED-NAME (Type or Print) FLOYD First Middle Last			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> HOUR		
3. SEX Male			4. RACE White		
5. DATE OF BIRTH June 17, 1924			6. AGE (In years, last birthday) 44 YRS		
7a. BIRTHPLACE (State or foreign country) West Va.			7b. CIT ZEN OF WHAT COUNTRY? U S A		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH BALTO. Colorado			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove State Hospital		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USLA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE West Vir COUNTY 13			13c. CITY OR TOWN August		
14. FATHER'S NAME William First Middle Last			15. MOTHER'S MAIDEN NAME Minnie First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes			16b. SOCIAL SECURITY NO 227-22-2362		
17. INFORMANT Mrs. Pauline King			ADDRESS Augusta, West Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: Chronic Alcoholism IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 19 P.M.		
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		
21f. LOCATION Street or R.F.D. No			City or Town		
County			State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Edward F. Wilson			M.D.		
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
			ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Dec. 10/68		
23c. NAME OF CEMETERY OR CREMATORY Augusta Cemetery			23d. LOCATION (City or Town) Augusta, Hampshire WVa. (County) (State)		
24. FUNERAL DIRECTOR Harry W. Haight			ADDRESS Sylva, Md.		
25a. REC'D BY REGISTRAR DEC 12 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

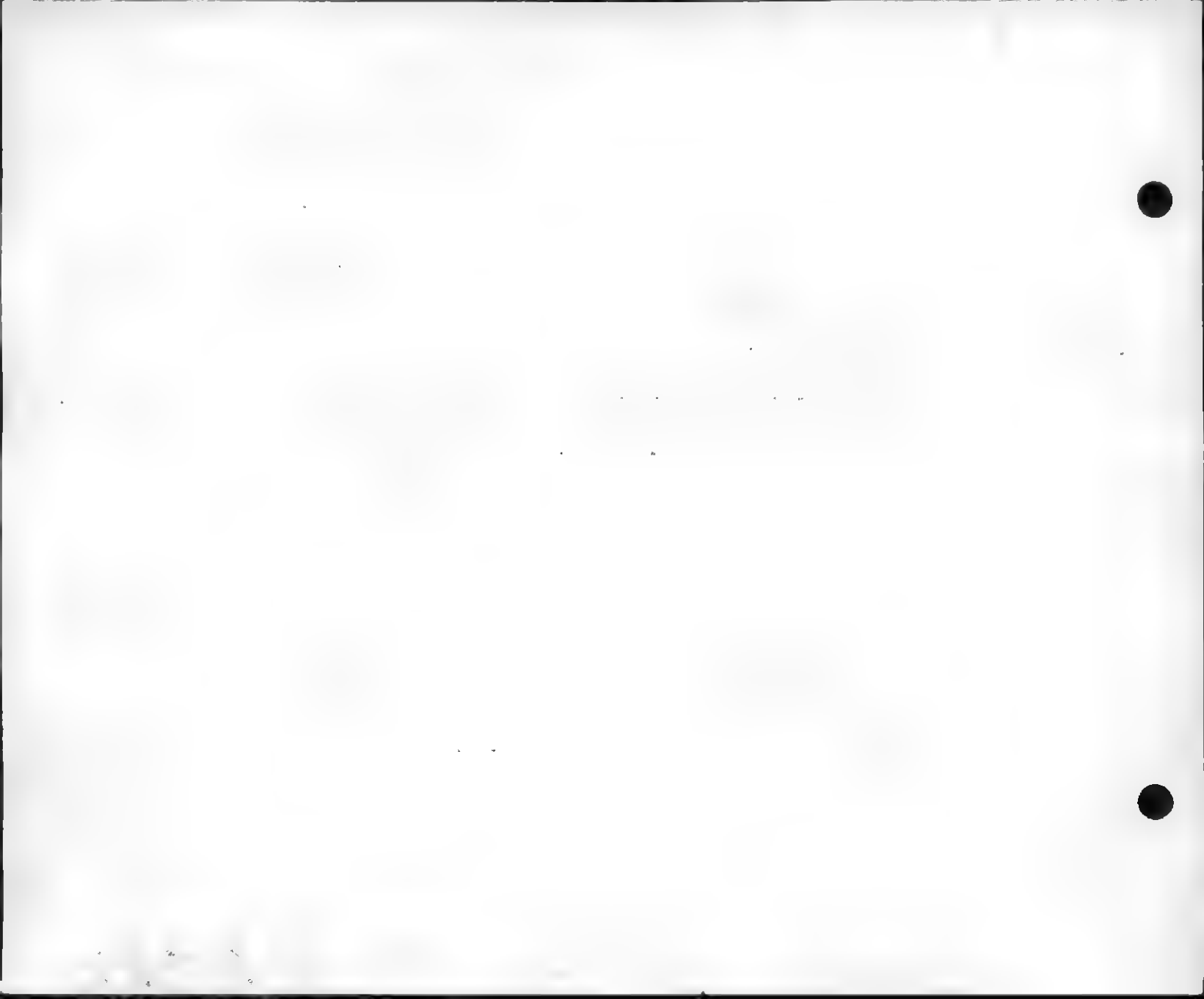


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1-65

<div style="display: flex; justify-content: space-between;"> 17102 MARYLAND STATE DEPARTMENT OF HEALTH 17112 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>													
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR				
Richard			Klausmeyer			Month 12 Day 27 Year 1968			7 40 A M				
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7 UNDER 1 YEAR		IF UNDER 24 HRS		
Female / Male		White		November 11, 1892			76 YRS		MONTHS DAYS		HOURS MIN		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH				
Maryland			U.S.A.						Baltimore,			Md	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Towson			St. Joseph Hospital			President			Tire Sales				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			3d INS DE CITY LIMITS?			13e STREET AND NUMBER	
Maryland			Baltimore			Baltimore			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			510 Anneslie Rd.	
14 FATHER'S NAME			15 MOTHER'S M A D E N NAME										
First Middle Last			First Middle Last										
Emil Klausmeyer			Francis Roth										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			Address				
no			---			218-32-1214 A			Mrs. Helen E. Klausmeyer-510 Anneslie Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Respiratory Insufficiency													
472x DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 53-5x (b) Pulmonary Fibrosis and Emphysema													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)													
Acute tracheo-bronchitis													
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
			HOUR A.M. Month Day Year P.M. 19										
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No			City or Town			County State	
22a I certify that (X) (this hospital) attended the deceased from 12-20, 19 68, to 12-27, 19 68, that (X) (we) last saw the deceased alive on 12/27/19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE			22c. DATE SIGNED			22d PHYSICIAN'S NAME (Type)			22e. ADDRESS				
[Signature]			12/27/68			Reynaldo Orjuela-Gomez			6500 York Rd., Towson, Md. 21204				
22d PHYSICIAN'S NAME (Type)			22e. ADDRESS										
Reynaldo Orjuela-Gomez			6500 York Rd., Towson, Md. 21204										
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
Burial			12/30/68			Dulaney Valley Mem.			Balto. Co.				
24 FUNERAL DIRECTOR			25a REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
[Signature]			JAN 3 1969			[Signature]							



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI- DEATH MATED			Month Day Year		2b HOUR
GEORGE IRVING KLEIN, JR.						19					M
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year		2d HOUR	
Male	White	11/8/25	43 YRS					December 1,		12:30 P. M.	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Maryland			U.S.A.						BALTIMORE Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Woodlawn			Bexhill Rd. (wooded area)			Fireman			Railroad		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Md.			Baltimore			Arbutus			405 S. Beechfield Avenue		
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
George I. Klein, Sr.			Alberta Hampton								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT ADDRESS					
Yes.			W. W. T. 220-14-9598			George I. Klein, Sr. 5516 Gunther Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute bronchopneumonia											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
471X EXPOSURE											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day Year ? ? 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
						Found in wooded area					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State					
			Woods			Woodlawn Baltimore Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			Charles S. Springate, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED December 2, 1968		
EXAMINER'S NAME (Type)						ADDRESS (Street, city, town, or county)					
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			12/4/68			Baltimore National Cemetery			Baltimore, Maryland		
24 FUNERAL DIRECTOR			ADDRESS			25a REG BY REG STRAR DATE			25b REG STRAR'S SIGNATURE		
Ambrose Ino 1328 Sulphur Sp Rd.						DEC 9 1968			Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

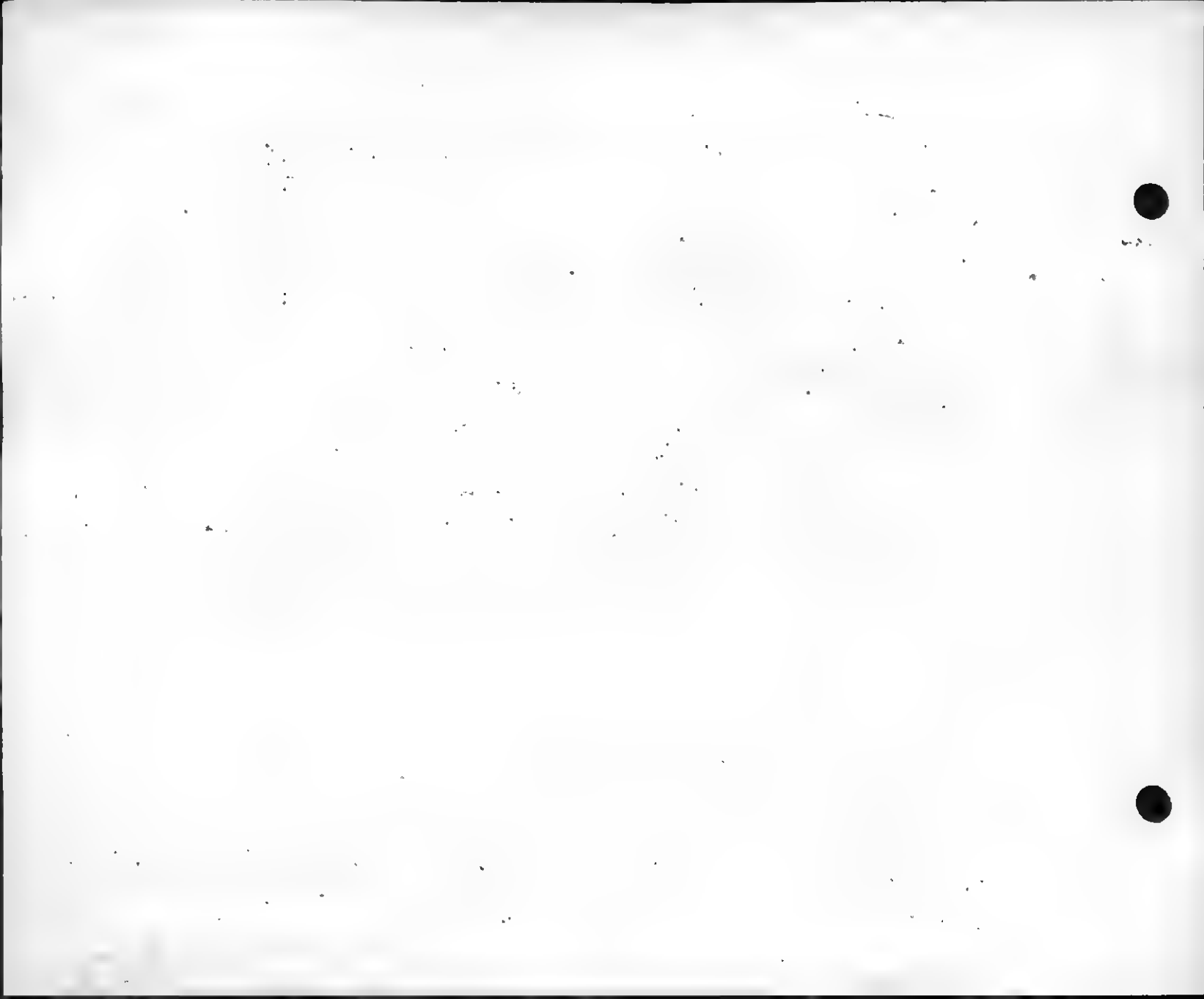
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17104

CERTIFICATE OF DEATH

17114

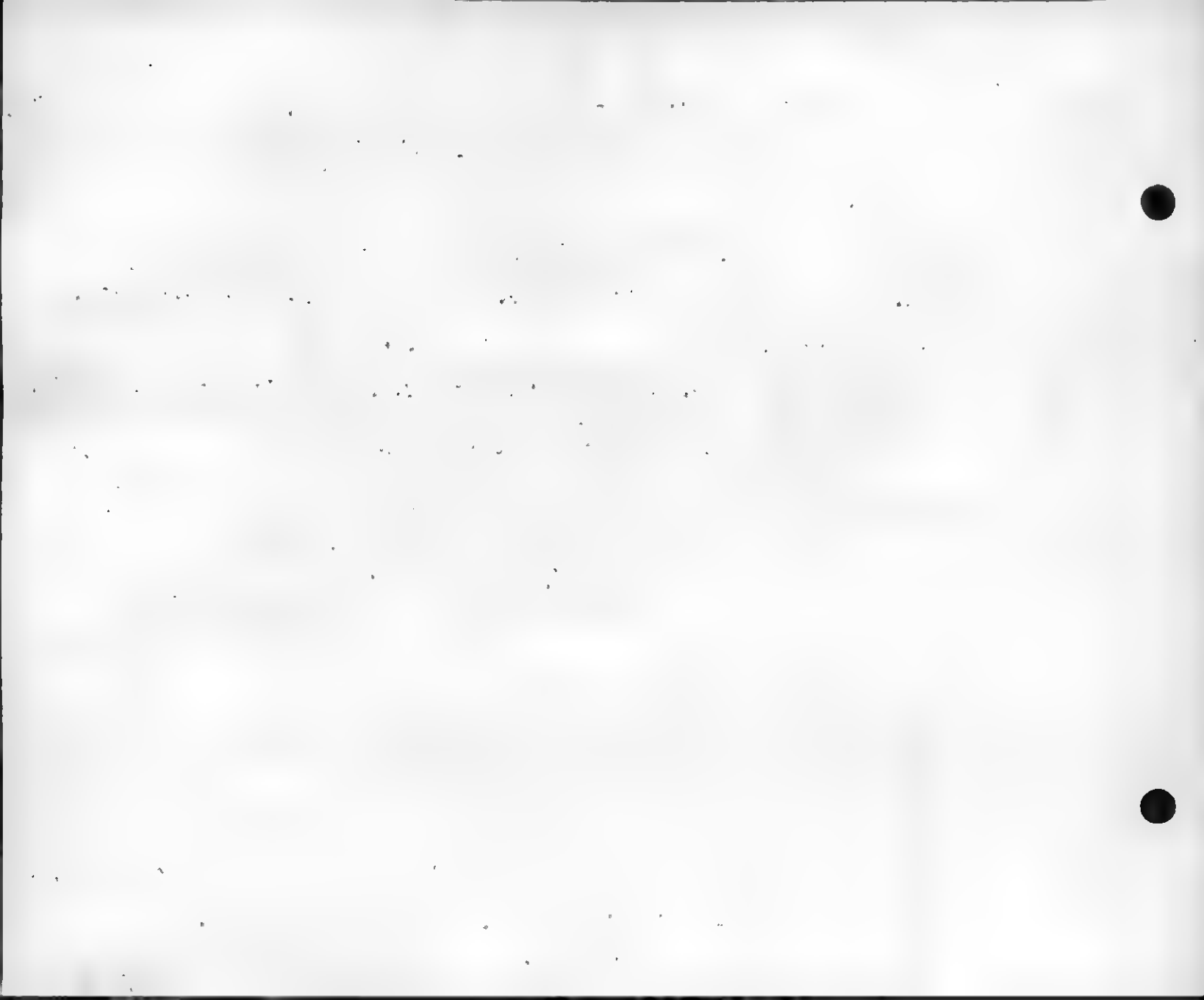
1. DECEASED NAME (Type or print) Henry J. Klein Jr.		2a. DATE OF DEATH Month 12 Day 15 Year 1968		2b. HOUR 2:30 AM
3. SEX M	4. RACE W	5. DATE OF BIRTH 12-18-1915	6. AGE (in years last birthday) 52 YRS.	7. UNDER YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Md	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Fireman	12b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE Md	13b. COUNTY Baltimore	13c. CITY OR TOWN Parkville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 8814 PEARL AVE
14. FATHER'S NAME First Henry J. Middle Klein Last Klein	15. MOTHER'S MAIDEN NAME First Alice T. Middle Kelly Last Kelly			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give year or years of service)	16b. SOCIAL SECURITY NO. 123-45-6789	17. INFORMANT Mildred Klein Address Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction - Acute DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease (Vessel)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. Severe
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from 7-22-1965 to 12-15-1968 , that (I) (we) last saw the deceased alive on 12-15-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Dead at St. Joseph's admission.				
22b. SIGNATURE John C. Hyle	DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 12-16-68		
22d. PHYSICIAN'S NAME (Type) JOHN C. Hyle	22e. ADDRESS 7527 Breun Rd. Balt 21236 Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12-18-68	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley	23d. LOCATION (City or Town) (County) (State) Cockeysville Md	
24. FUNERAL DIRECTOR CHAS. F. EVANS + Son	ADDRESS 8802 Harbor Rd	25a. REC'D BY REGISTRAR DATE DEC 18 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2a should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17115		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		17115	
Item 5 Film 107 12/23/68 wk		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print) Henrietta J. Konitzky		First Middle Last		2a. DATE OF DEATH Dec. 12.68 Month Day Year	
3. SEX F		4. RACE W		2b. HOUR 5:30 P.M.	
5. DATE OF BIRTH April 11/68		6. AGE (In years last birthday) 1874 94 YRS		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY?		9. COUNTY OF DEATH Baltimore Md.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Augsburg Luth Home	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret-ired) Teacher		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Balto.	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4316 Bellvieu Ave.			
14. FATHER'S NAME John Henry Konitzky		First Middle Last		15. MOTHER'S MAIDEN NAME Marie Stueler	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown		16b. SOCIAL SECURITY NO. 213-50-7213		17. INFORMANT Records Aug. Luth Home	
16c. ADDRESS 5811 Campfield					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senile Psychosis DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 2 yrs.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Generalized Arterio Sclerosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 10 , 19 63 , to 12/12 , 19 68 , that (I) (we) lost saw the deceased alive on Dec. 5 - 1968 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) view the body after death.					
22b. SIGNATURE Earl L. Chambers, M.D.		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/13/68	
22d. PHYSICIAN'S NAME (Type) Earl Chambers		22e. ADDRESS 400-W. Cold Spring Lane Balto. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/16/68		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	
23d. LOCATION (City or town) (County) (State) Balto Md.					
24. FUNERAL DIRECTOR P.A. Heemann 6067 Harford Rd.		ADDRESS		25a. REC'D BY REGISTRAR DEC 16 1968	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

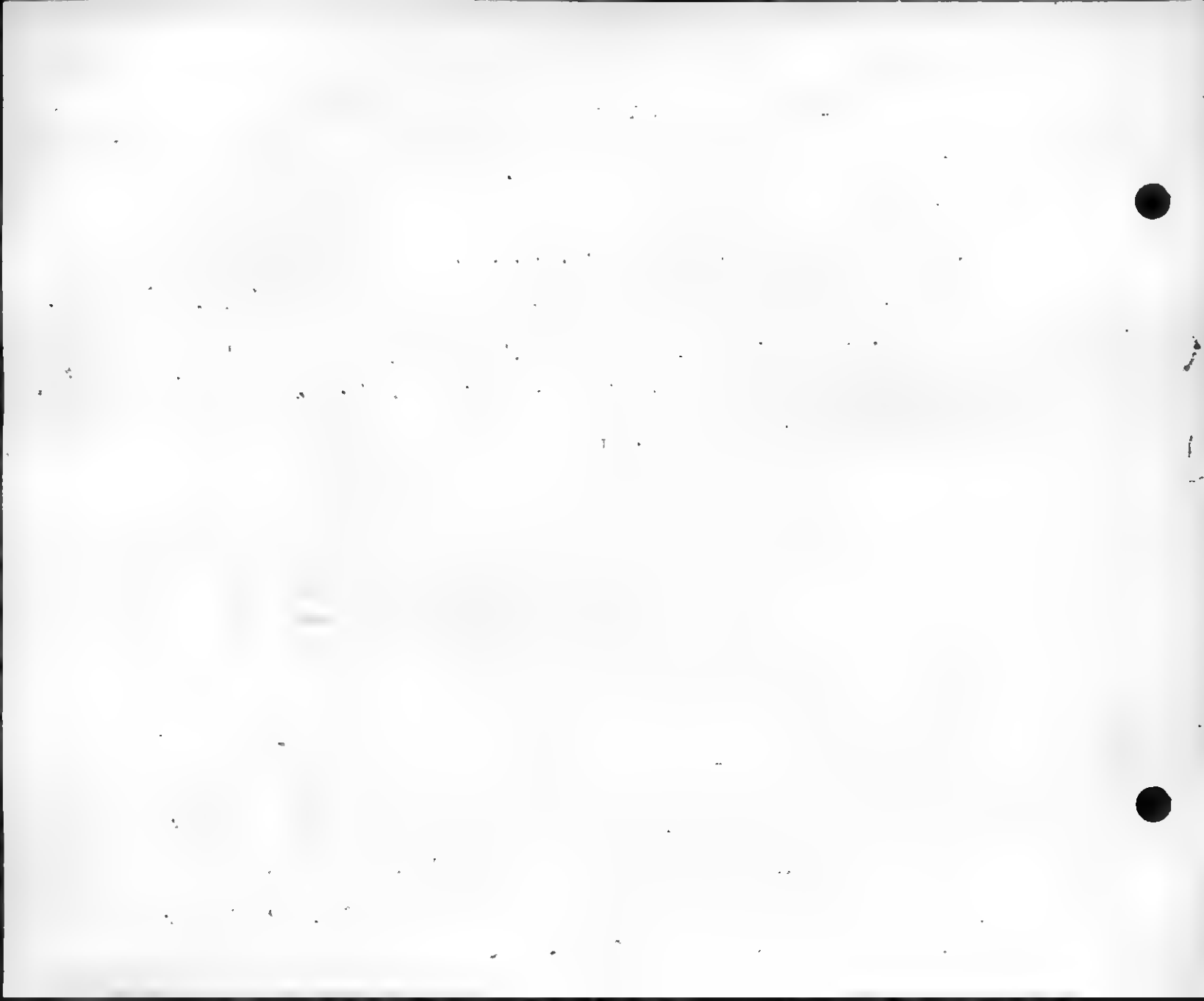
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

171198

171116

1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH				2b. HOUR a			
DOROTHY		PEARL		KOTLARZ				12 Month 14 Day 68 Year				1:40 M			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
FEMALE		CAUCASIAN		10-19-12				56 YRS.		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH									
PENNA		U.S.A.				BALTIMORE									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY					
TOWSON		GREATER BALTO. MED. CENT.													
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER							
md.		BALTIMORE		DUNDALK		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2609 LIBERTY PKWY.							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last	
STANLEY		KRAWCZAK		PEARL		DOBRO NIECKI									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address							
NO				NONE		NORBERT V. KOTLARZ		AS IN # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) BRAIN TUMOR															
DUE TO, OR AS A CONSEQUENCE OF															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
		HOUR A.M. Month Day Year P.M. 19													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION				Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (a) (this hospital) attended the deceased from 11-30, 19 68, to 12-14, 19 68, that (I) (we) last saw the deceased alive on 12-13, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE		22c. DATE SIGNED													
Paul J. Edgar, M.D.		12-14-68													
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS													
PAUL J. EDGAR		6701 N. CHARLES ST.													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)					
BURIAL		12/17/68		SACRED HEART		BALTO. CO., MD.									
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
W. Brooke Riddle, Baltimore, Md.		DATE DEC 17 1968				J. Charles Judge									



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1515
45M

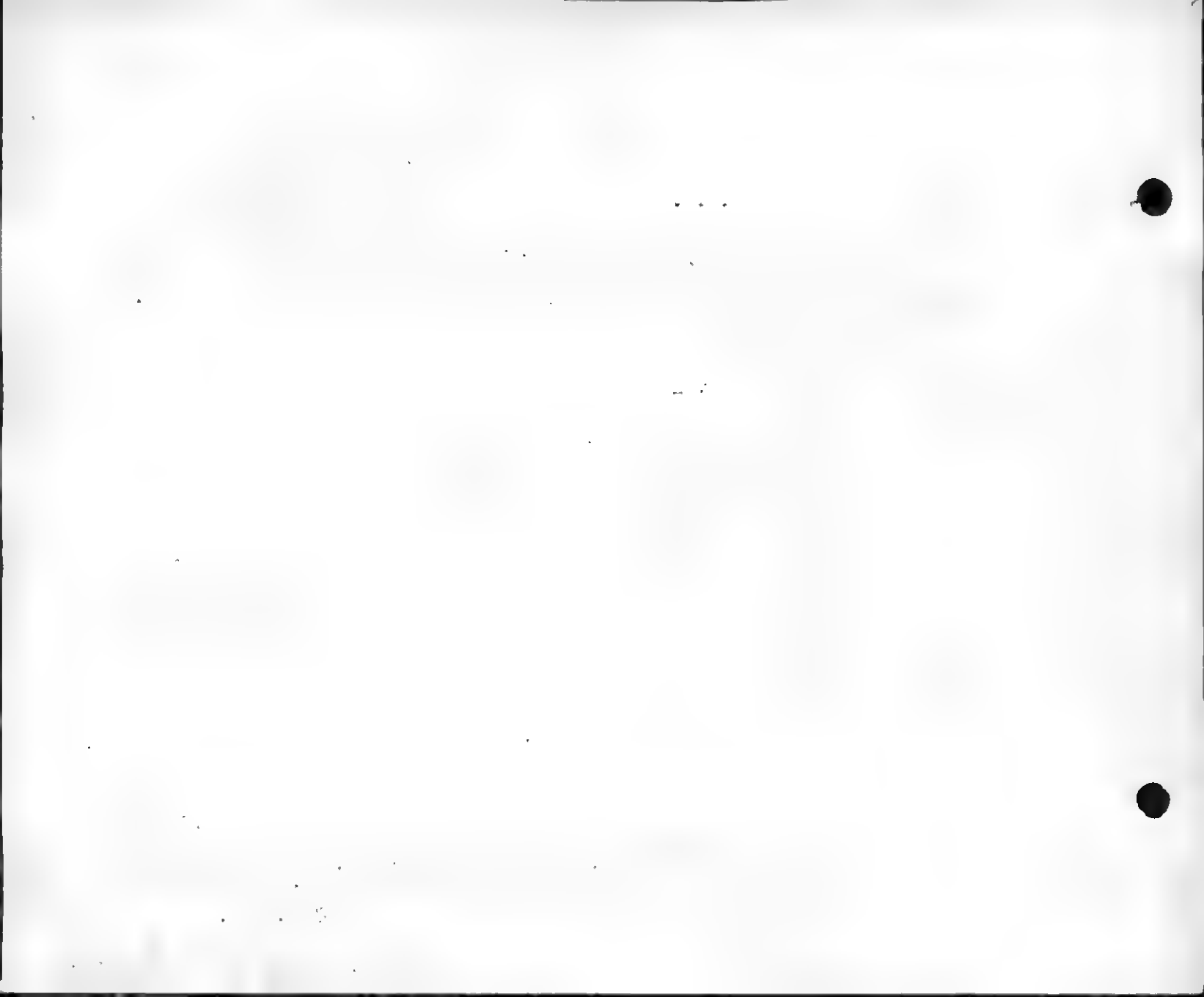
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17107

17117

1 DECEASED-NAME (Type or print)		First Middle Last		2a DATE OF DEATH		2b HOUR	
Josephine		KOZEL		Month Day Year 12 31 1968		7 A.M.	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
Female	White	March 15, 1885		83 YRS			
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8-MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Czechoslovakia	U.S.A.			Baltimore, Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Towson		St. Joseph Hospital		Homemaker Packer		Langs Piddle Co	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER		
Maryland		17	Baltimore	YES <input type="checkbox"/> NO <input type="checkbox"/>	6100 Bertram Ave.		
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME					
First Middle Last		First Middle Last					
John Brezina		Unknown					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT Address			
no		217-18-1626 A		Mary Westfall, sister, above			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							
(b) Acute myocardial infarction							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
4201							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTE <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or RFD No. City or Town County State			
22a I certify that (A) (this hospital) attended the deceased from 12/17/ 1968, to 12/31/ 1968, that (X) (we) last saw the deceased alive on 12/31/ 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (aid not) view the body after death.							
22b SIGNATURE				DEGREE ATTENDING PHYS <input type="checkbox"/> MED <input type="checkbox"/> STAFF DIRECTOR <input type="checkbox"/> PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED	
Christina Feliciano, M.D.						12/31/68	
22d PHYSICIAN'S NAME (Type)				22e ADDRESS			
				7620 York Rd., Towson, Md. 21204			
23a BURIAL, CREMATION (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		1/3/69		Oak Hill Cemetery		Balto., Md.	
24. FUNERAL DIRECTOR				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Schimunek Funeral Home 3331 Brehms Lane 21213				DATE JAN 3 1969		Charles Judge	



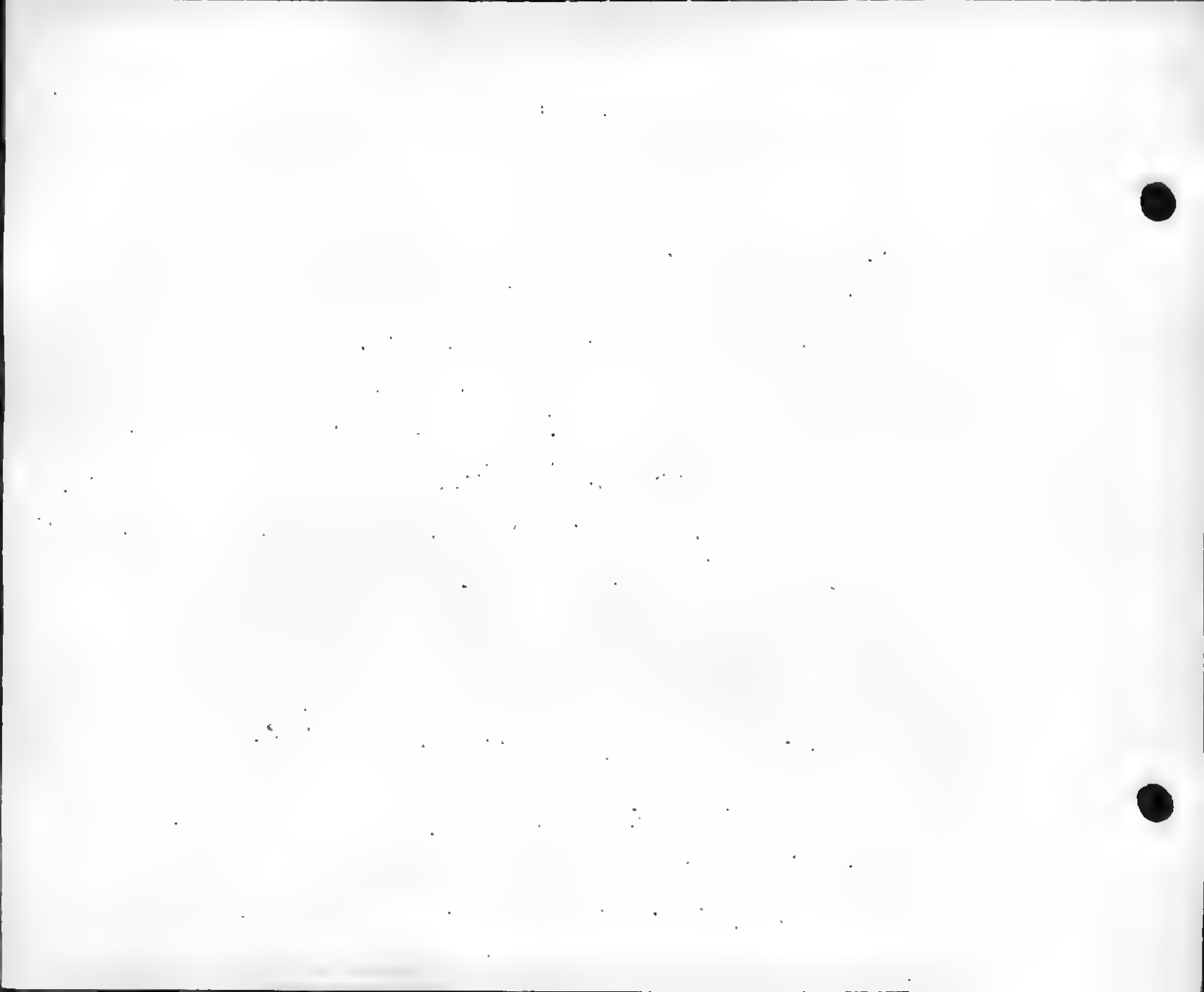
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
304A REV. 1/68

17108		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17118	
CERTIFICATE OF DEATH							
1. DECEASED NAME (Type or print) WILLIAM E. KRAMER		First Middle Last		2a. DATE OF DEATH DEC Month 18 Day 1968 Year		2b. HOUR 8 30 AM	
3. SEX M	4. RACE W	5. DATE OF BIRTH MAR. 21, 1905		6. AGE (In years last birthday) 63 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MO.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH BALTO.		Md.	
10. CITY OR TOWN OF DEATH ESSEX		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4 S. GOELLER AVE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY BALTO	13c. CITY OR TOWN ESSEX	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 4 S. GOELLER AVE		
14. FATHER'S NAME First Middle Last WILLIAM T. KRAMER		15. MOTHER'S MAIDEN NAME First Middle Last DORA REDMERS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown UNK (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address JOHN YOUNGER 74 WILTSHIRE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF, Coronary insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Diabetes, Arteriosclerosis. (b) (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Heart failure, chr. Liver cirrhosis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 weeks 3 years several years	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State November 16, December 18, 1968			
22a. I certify that (I) (the hospital) attended the deceased from November 16, 1968 to December 18, 1968 , that (I) (we) last saw the deceased alive on December 10, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Eugene C. Baumann		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-19-68			
22d. PHYSICIAN'S NAME (Type) Eugene C. Baumann		22e. ADDRESS 413 Eastern Ave Baltimore 21, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12/21/68		23c. NAME OF CEMETERY OR CREMATORY MEBELAND		23d. LOCATION (City or Town) (County) (State) BALTO. MD.	
24. FUNERAL DIRECTOR J.G. CONNELLY SONS		ADDRESS 300 MACE		25a. REC'D BY REGISTRAR DEC 24 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

MEDICAL CERTIFICATION



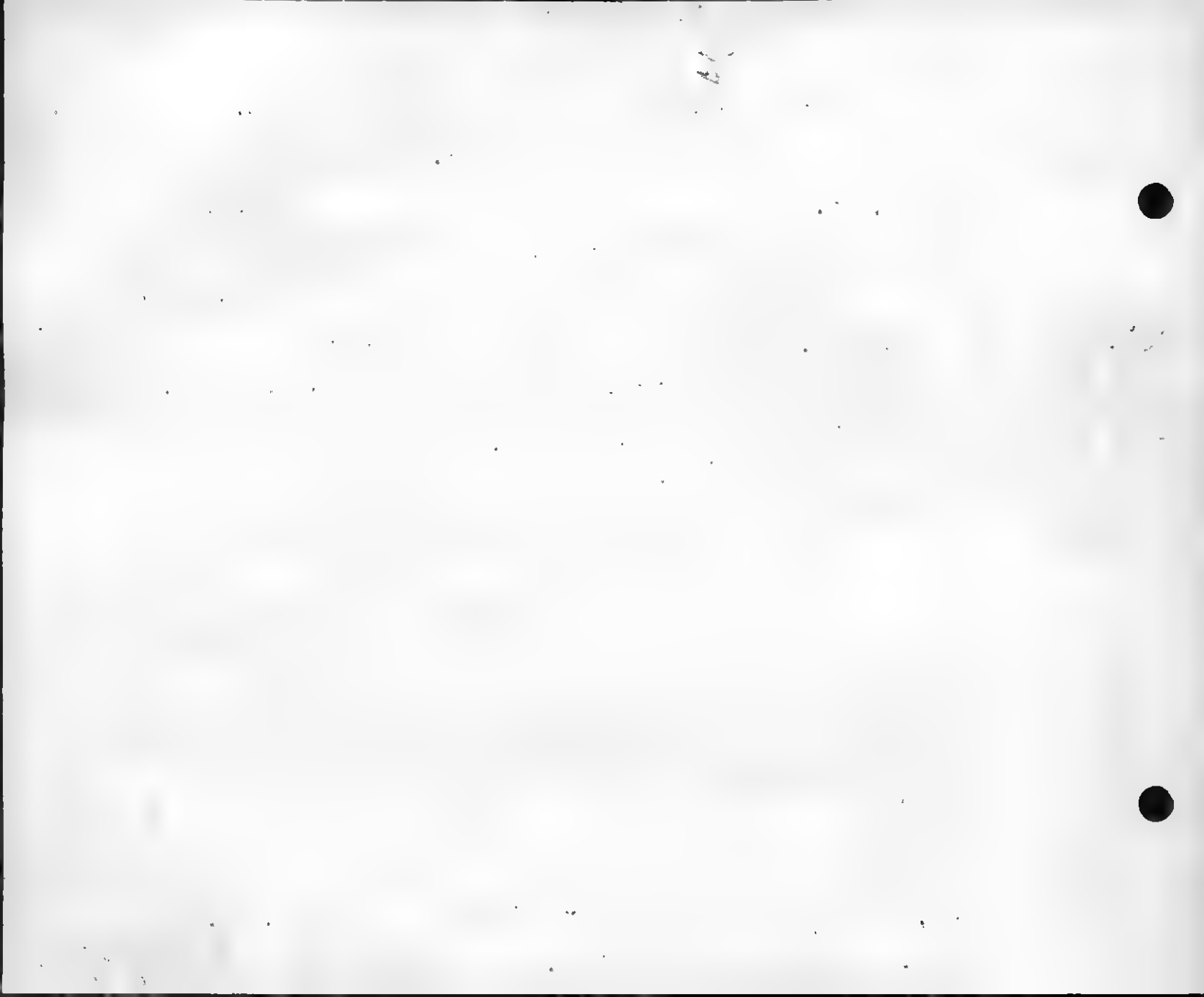
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
171199									
17119									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Elvira Kruelle						Dec. 14, 68			6.30M
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR	
F	W		Apr. 24, 14			54 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Balto. Md.		U.S.A.				Baltimore Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Towson			8317 Ridgley Oak			Teller			Bank
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md			Balto		Towson		YES <input type="checkbox"/> NO <input type="checkbox"/>		8317 Ridgley Oak
14. FATHER'S NAME First Middle Last					15. MOTHER'S M.A.D.E.N. NAME First Middle Last				
Howard W. Shamleffer					Carrie Bauer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT			Address	
(If yes give war or dates of service)			212-05-7159		Mathias Kruelle			Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>									7 min
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF									
(b) _____									
(c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1 May</u> , 19 <u>68</u> , to <u>14 Dec</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10 Dec</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
									16 Dec 68
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
					6067 Harford Rd. Balto. (34) Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12/17, 68		Gardens Faith		Balto. Md.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
P.A. Heemann 6067 Harford Rd.					DEC 20 1968		J. Charles Judge		

MED. CAL. CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) GEORGE M KURTZ		2a. DATE OF DEATH Month Dec Day 31 Year 68		2b. HOUR 7:56^A M
3. SEX M	4. RACE W	5. DATE OF BIRTH 3-18-96	6. AGE (In years last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS 72 DAYS 72
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE Md.	
10. CITY OR TOWN OF DEATH RANDALLSTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BALTO. COUNTY GEN. HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ASST. TREASURER	12b. KIND OF BUSINESS OR INDUSTRY U.S. F&G	
13a. USUAL RESIDENCE (Where deceased lived, first institution residence before admission) STATE MD	13b. COUNTY BALTO.	13c. CITY OR TOWN RANDALLSTOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3734 OFFUTT RD
14. FATHER'S NAME First GEORGE Middle W. Last KURTZ	15. MOTHER'S MAIDEN NAME First VIRGINIA Middle MITCHELL Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO 215-07-8584	17. INFORMANT Address DONALD J. KURTZ, 54 ACORN CIRCLE, TOWSON		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Brain Tumor - R. Post. Quad. 2381 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
MEDICAL CERTIFICATION				
19a. DATE OF OPERATION	19b. COMBINATION FOR WHICH OPERATION WAS PERFORMED	20a. ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from Dec 16 , 19 68 , to Dec 31 , 19 68 , that (I) (we) last saw the deceased alive on Dec 31 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Gregorio Towson MD	DEGREE	ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED 12-31-68	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS			
23a. BURIAL, CREMATION (bury/cremate)	23b. DATE 1-4-1969	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson		ADDRESS 1050 York Road 21204		25a. REC'D BY REGISTRAR JAN 3 1969
		25b. REGISTRAR'S SIGNATURE J. Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR					
MARGARET ANNE LAM						Month Day Year 12-31-68			7:10 P.M.					
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (in years lost birthday)		7 UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		WHITE		6-4-1901			67 YRS		MONTHS DAYS		HOURS MIN.			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH					
Virginia			U.S.A.						Baltimore					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during major part of life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY					
Towson			St. Joseph's Hospital			Housewife			Home					
13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER		
Maryland			Baltimore			Towson			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			11 E. Chesapeake Ave. 04		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
First Middle Last			First Middle Last											
George Kyger			Gernie May Shifflett											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT			Address					
No			-----			Leonard Kyger			McGaheysville, Virginia					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Hepatic insufficiency														
5/7/69 DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														
(b) Cirrhosis of the liver														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
5/7/69														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (X) (this hospital) attended the deceased from 9-29-68, 1968, to 12-31-68, 1968, that (X) (we) lost the deceased alive on 12-31-1968, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death														
22b. SIGNATURE														
Gualberto Gokim, Jr. M.D. DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>														
22c. DATE SIGNED 12-31-68														
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS											
Gualberto Gokim, Jr. M.D.			7620 York Road, Baltimore, Md. 21204											
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			1-2-1969			Mt. Olivet Cemetery			McGaheysville, Virginia					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Wm. Cook-Brooks Towson			1050 York Road Towson			JAN 3 1969			Charles Judge					



CERTIFICATE OF DEATH

17122

1. DECEASED-NAME (Type or print) Leo Michael Lambert			2a. DATE OF DEATH Month December Day 6 Year 1968			2b. HOUR 1:30	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Feb. 23, 1885		6. AGE (In years last birthday) 83 YRS.	
7a. BIRTHPLACE (State or foreign country) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY Printer	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last John P. Lambert		15. MOTHER'S MAIDEN NAME First Middle Last Barbara Lutz		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			
16b. SOCIAL SECURITY NO. 217-03-0461		17. INFORMANT Address Mr. Lee E. Lambert 2206 Taylor Ave. 21234					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 41							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (A) (this hospital) attended the deceased from December 5, 1968 , to Dec. 6, 1968 , that (A) (we) last saw the deceased alive on December 6, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Francis T. Daly, M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED 12/6/68	
22d. PHYSICIAN'S NAME (Type) Francis T. Daly, M.D.						22e. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 9, 68		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Parkville Maryland	
24. FUNERAL DIRECTOR Loring Byers Funeral Home Randallstown, Md.				25a. REC'D BY REGISTRAR DEC 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

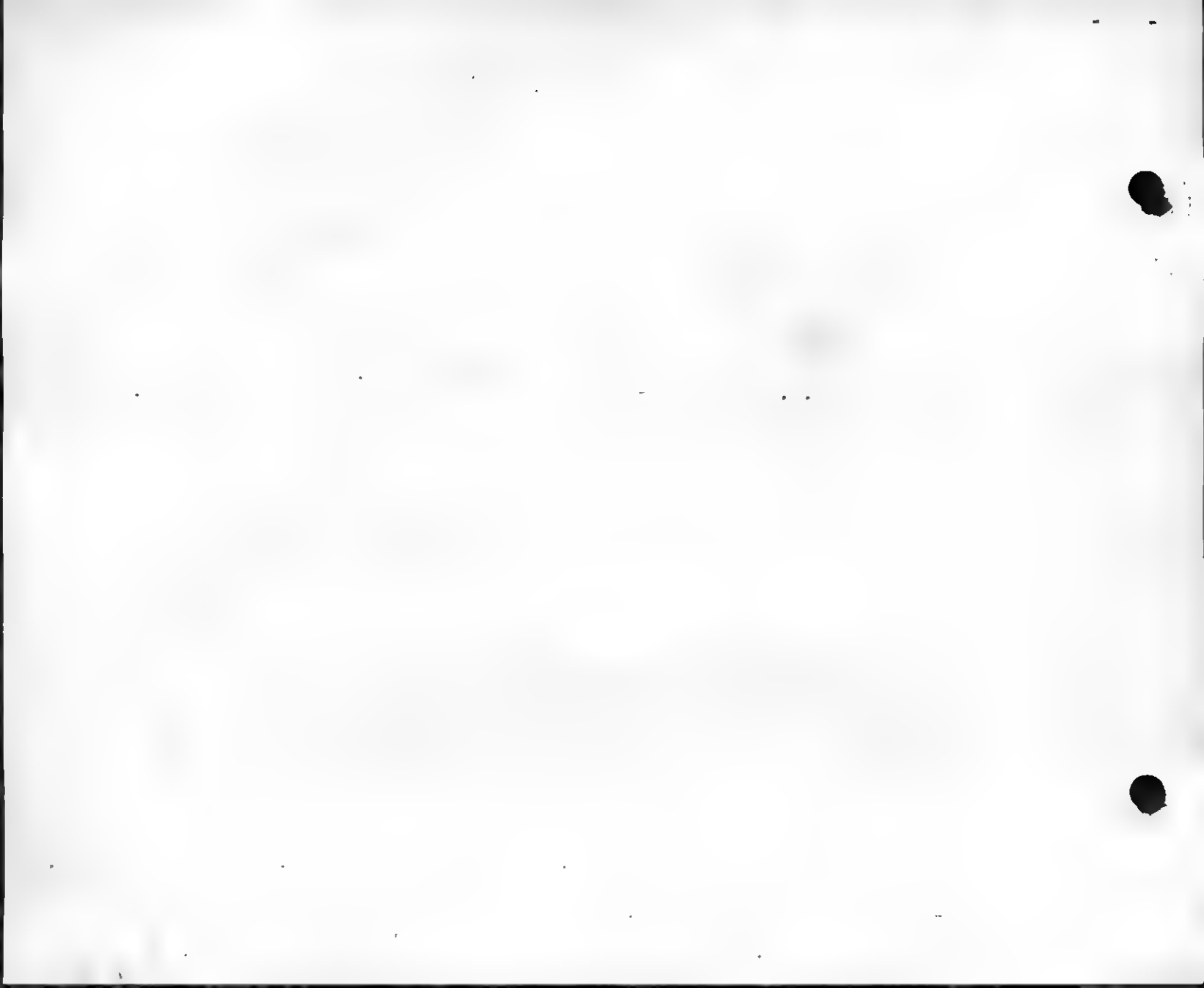
17113
~~17113~~

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17123

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Morris		First (LEMPER, LAMPELL)		Middle LAMPELL		2a. DATE OF DEATH Month Dec Day 6 Year 68		2b. HOUR 1 A. M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH [REDACTED]		6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (State or foreign country) AUSTRIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		Md.	
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. Co. Gen. Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) TAILOR		12b. KIND OF BUSINESS OR INDUSTRY CLOTHING			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. CITY OR TOWN Balto		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 6976 Mil Brook Ave Dr			
14. FATHER'S NAME First harris Middle Lampel Last Fuder		15. MOTHER'S MAIDEN NAME First Rachel Middle Last Fuder		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES (If yes give war or dates of service) W.W. I ARMY 056-01-6805		16b. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT MRS. NETTIE LAMPELL 6976 MILBROOK PARK DR. #15	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart dis. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) [REDACTED]									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days
19a. DATE OF OPERATION [REDACTED]		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED [REDACTED]		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? [REDACTED]			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) [REDACTED]		21b. TIME OF INJURY HOUR A.M. Month Day Year 1968 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) [REDACTED]					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING ETC [REDACTED]		21f. LOCATION Street or RFD No City or Town County State 					
22a. I certify that (I) (this hospital) attended the deceased from DEC 3, 1968 to DEC 6, 1968 , that (I) (we) last saw the deceased alive on DEC 6, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d d) (did not) view the body after death									
22b. SIGNATURE Philip Bernstein		DEGREE 		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 12-6-68			
22d. PHYSICIAN'S NAME (Type) Philip Bernstein, M.D.		22e. ADDRESS 112 Chartley Dr., Reisterstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-8-68		23c. NAME OF CEMETERY OR CREMATORY MT. HEBRON		23d. LOCATION (City or Town) (County) (State) Flushing, Long Island, New York			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS 		25a. REC'D BY REGISTRAR DATE DEC 10 1968		25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 4Y
45M 1/68

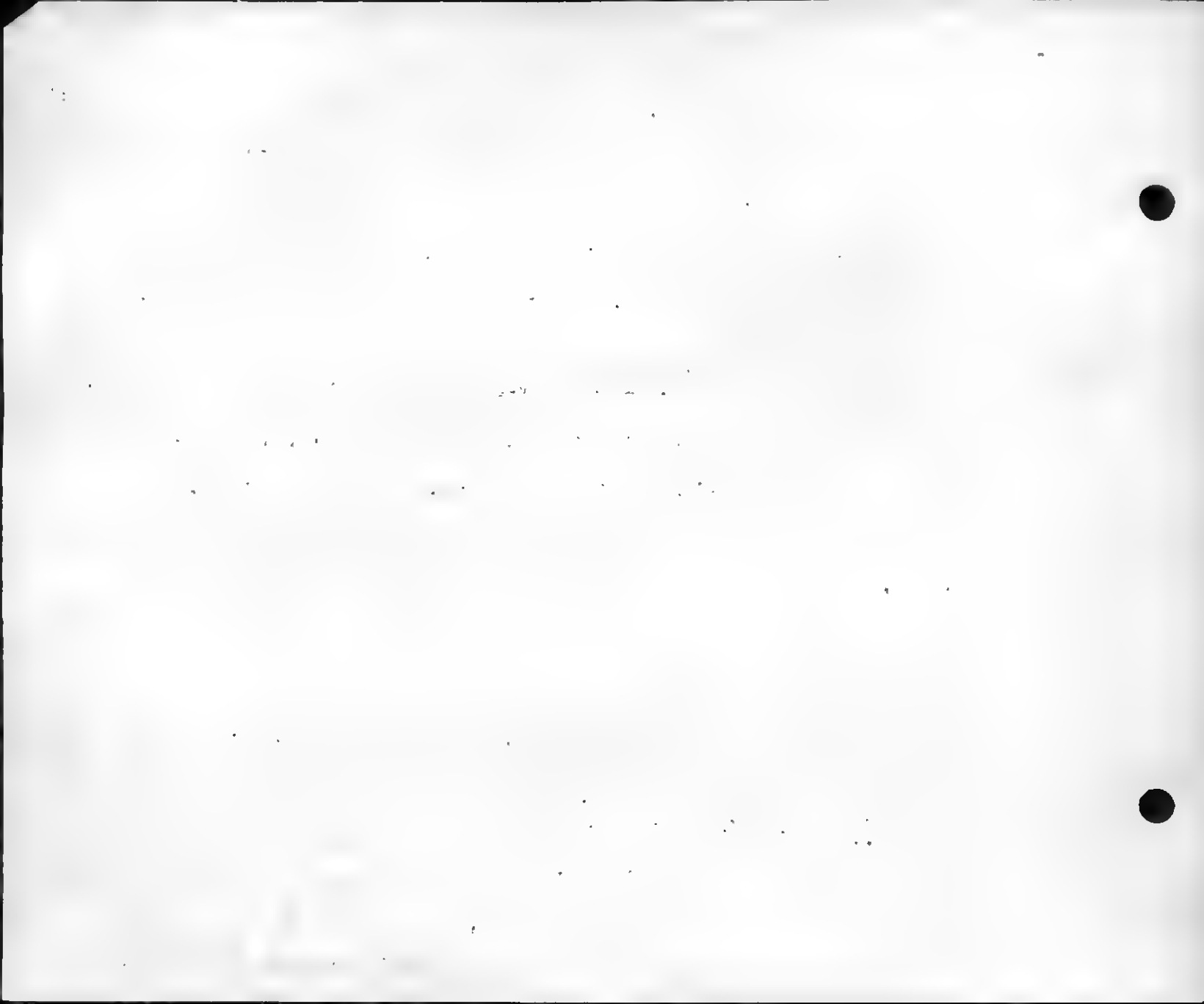
MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOJR		
Theresa Marie LANDA						Month Day Year 12 12 1968		9:50 AM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		7. IF UNDER 1 YEAR		
Female		White		April 2, 1896		72 3/4 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTH-PLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Czechoslovakia		USA				Baltimore,		Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson			St. Joseph Hospital			Homemaker				
13a. U.S.A. RESIDENCE (Where deceased had residence at time of death) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Baltimore		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		318 Townsend Rd.	
14 FATHER'S NAME First Middle Last			5 MOTHER'S M.A.D.E.N NAME First Middle Last							
CHARLES MRAZ			MARIE PALAK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
NONE					MARIE URBAN					
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute myocardial infarction										
4109 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (A) (this hospital) attended the deceased from 11/23/1968, to 12/12/1968, that (A) (we) last saw the deceased alive on 12/12/1968, and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death										
22b. SIGNATURE				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/12/68				
22d. PHYSICIAN'S NAME (Type) Samuel C.H. Lee, M.D.				22e. ADDRESS 7620 York Rd., Towson, Md. 21204						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		12/16/68		HOLY REDEEMER		BALTE. MD.				
24 FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
J.G. CONNELLY SONS 300 MACE				DATE DEC 16 1968		J. Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div> <div> <div>7</div> <div>1</div> </div> <div> <div>Items 14, 15, 16, 23 & 24</div> <div>Film 0407 12/19/68 KK</div> </div> <div> <div>17115</div> <div>CERTIFICATE OF DEATH</div> </div> <div> <div>17125</div> <div></div> </div> </div> <div> <div> <div>1</div> <div>DECEASED-NAME (Type or print)</div> </div> <div> <div>First</div> <div>Gladys</div> </div> <div> <div>Middle</div> <div>I.</div> </div> <div> <div>Last</div> <div>Laubinger</div> </div> </div> <div> <div>2a. DATE OF DEATH</div> <div> <div>Month</div> <div>December</div> <div>Day</div> <div>7</div> <div>Year</div> <div>1968</div> </div> <div> <div>2b. HOUR</div> <div>4:15</div> <div>AM</div> </div> </div>													
3 SEX	female	4 RACE	white	5 DATE OF BIRTH	March 20, 1910	6 AGE (In years lost birthday)	58 YRS	7c UNDER 1 YEAR	MONTHS	DAYS	IF UNDER 24 HRS	HOURS	MIN
7a BIRTHPLACE (State or foreign country)	Virginia	7b. CITIZEN OF WHAT COUNTRY?	U. S.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH			Baltimore Md					
10 CITY OR TOWN OF DEATH	Catonsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	SPRING GROVE STATE HOSP.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	housewife						
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	Md.	13b COUNTY	Pr. Geo.	13c CITY OR TOWN	Hyattsville	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER	3810 Oglethorpe Street					
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last				
Christopher G. Beadles			Rose E. Turner										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)	no			16b. SOCIAL SECURITY NO.	217-16-3583			17 INFORMANT	Address				
				Records: SPRING GROVE STATE HOSPITAL									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:												3 days	
IMMEDIATE CAUSE (a) Myocarditis with congestive ht. failure,													
DUE TO, OR AS A CONSEQUENCE OF													
(b) A2 Hong Kong Influenza (presumptive dx.)												3 days	
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
none.													
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
			HOUR A M Month Day Year										
			P.M. 19										
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from July 5, 1968, to Dec. 7, 1968, that (I) (we) last saw the deceased alive on Dec. 7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death													
22b SIGNATURE			22c. DATE SIGNED			11 Dec 68							
22d PHYSICIAN'S NAME (Type)			22e. ADDRESS			SPRING GROVE STATE HOSPITAL							
Anthony J. Young, M.D.			Baltimore, Maryland 21228										
23a. BURIAL CREMATION, REMOVAL (Specify)	23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial	12/21/68			Cedar Hill Cem.			Suitland, Pr. Geo., Maryland						
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE				
P. Gasch's Sons			4739 Balto. Ave. Hyattsville, Md.			DEC 13 1968			Charles Judge				

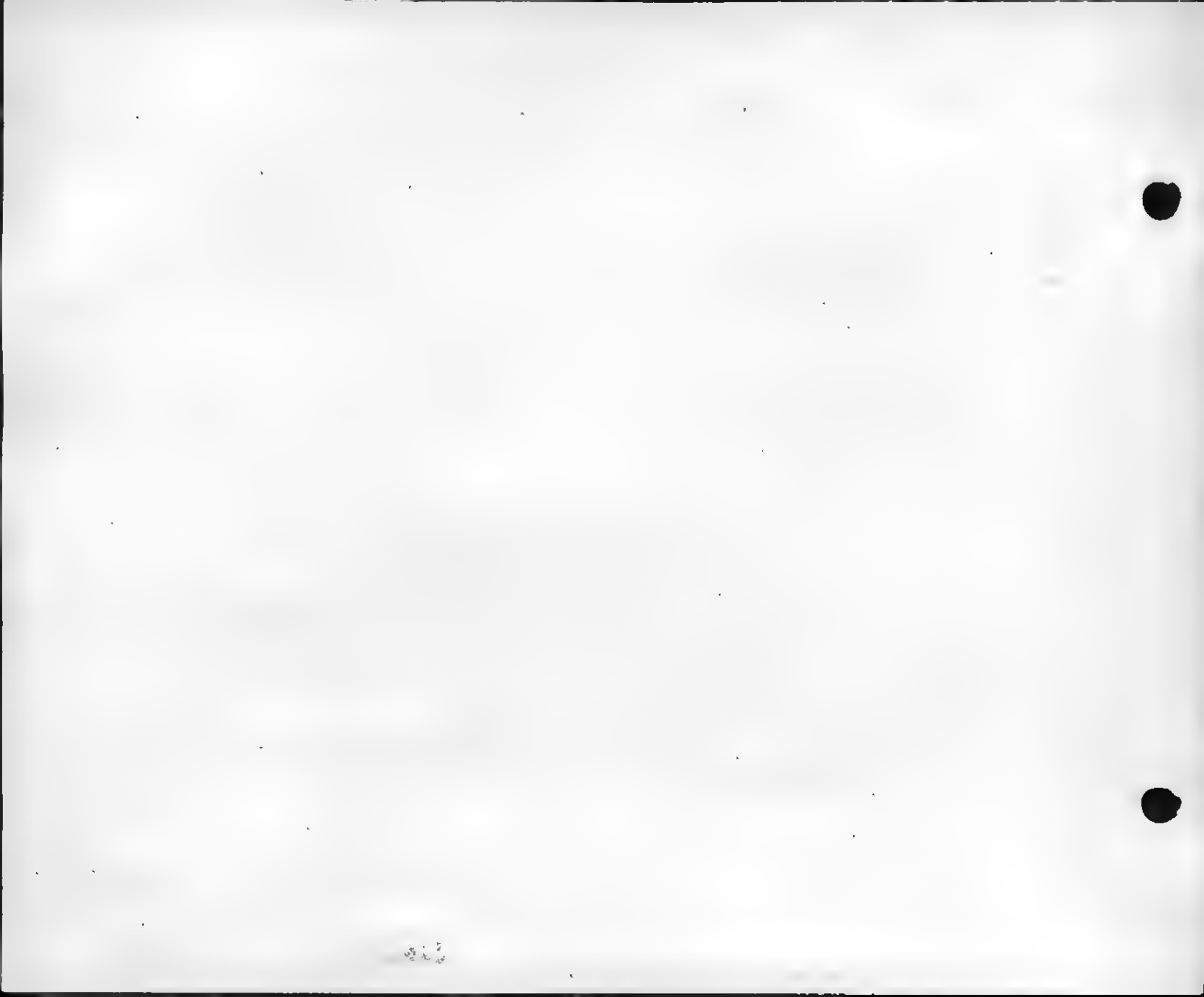


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove foregoing papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
17116					17126						
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Charles W Leiboldt						12 Month 29 Day 68			8:45A M		
3 SEX		4. RACE		5 DATE OF BIRTH			6 AGE (In years lost birthday)		F UNDER 1 YEAR IF UNDER 24 HRS		
Male		white		May 13, 1897			71 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Smithsburg			U.S.A.						Baltimore Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Owings Mills			Rosewood State Hosp			None					
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
Maryland			Washington						Unknown		
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Unknown			Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT			Address		
No			---			Rosewood Records			Owings Mills, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory insufficiency, bronchial obstruction										Terminal	
465X DUE TO, OR AS A CONSEQUENCE OF Chronic Pulmonary Disease										10 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										46 days	
(b) DUE TO, OR AS A CONSEQUENCE OF Upper respiratory tract infection Mucous obstr										terminal	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
institutionalized 68 yrs Chronic brain syndrome, Etiology Unknown											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from 13 Aug, 1966, to 29 Dec, 1968, that (X) (we) last saw the deceased alive on 29 Dec, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED		
Richard A. Jones M.D.									30 Dec 68		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
Richard A. Jones M.D.			Carroll County General Hospital								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			11/3/69			Rosewood Cemetery			Owings Mills, Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. RECD BY REGISTRAR DATE			25b. REGISTRAR'S SIGNATURE		
J. F. Gine & Sons			Reisterstown, Md.			JAN 6 1969			James J. Gine		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers' pages 1 and 2 should be filed with the State Dept. of Hy. 14th prior to burial, cremation, or removal, and in any event, within 72 hours after death.

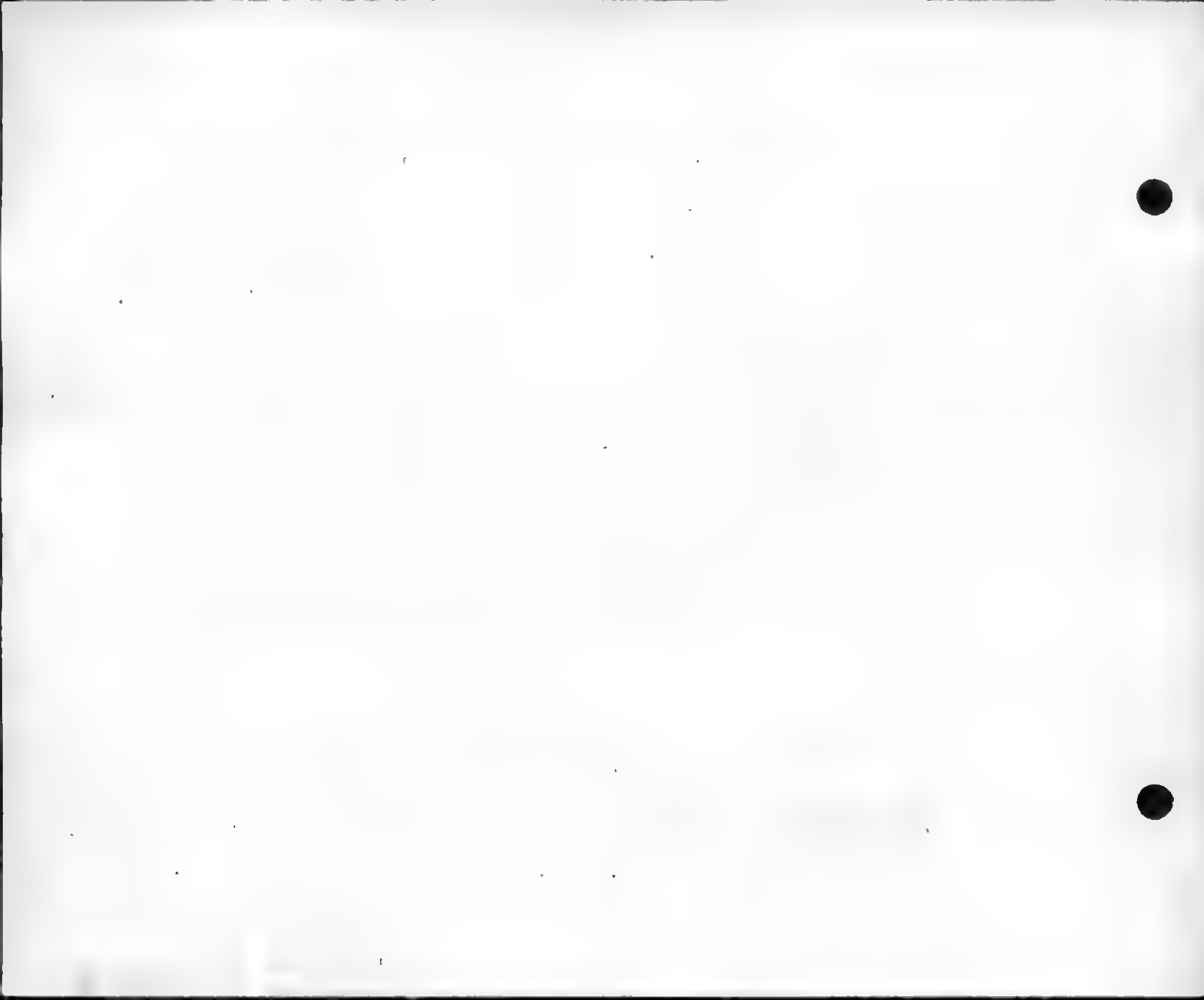
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

171127

CERTIFICATE OF DEATH

17127

1 DECEASED NAME (Type or print) FREDERICK		First E.	Middle E.	Last LEIMBACH	2a DATE OF DEATH Month DECEMBER Day 22 Year 1968		2b HOUR 2:55A		
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH AUGUST 20, 1901		6 AGE (In years last birthday) 67 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE,			
10 CITY OR TOWN OF DEATH TOWSON		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Hardware Owner		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b COUNTY BALTIMORE		13c CITY OR TOWN BALTIMORE		13d HOME CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 2920 O'DONNELL ST. #21224
14 FATHER'S NAME First George W. Middle Leimbach				15 MOTHER'S M A D E N NAME First Catherine Middle Schreiber Last					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		(If yes give war or dates of service) WW II		16b SOCIAL SECURITY NO		17 INFORMANT Mrs. Margaret E. Schumann Address 627 Yarmouth Rd.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (this hospital) attended the deceased from December 11, 1968 , to December 22, 1968 , that (we) last saw the deceased alive on December 22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (do not) view the body after death.									
22b SIGNATURE Gualberto E. Gokim, Jr. DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED DECEMBER 22, 1968	
22d PHYSICIAN'S NAME (Type) GUALBERTO GOKIM, JR., M.D.		22e ADDRESS 7620 YORK ROAD TOWSON, MD. #21204							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 12-24-68		23c NAME OF CEMETERY OR CREMATORY Oaklawn		23d LOCATION (City or Town) Baltimore, Maryland		(County) (State)	
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212				25a REC'D BY REGISTRAR DATE DEC 27 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge			



17118

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Long May Lipscomb			2a. DATE OF DEATH Month 12 Day 8 Year 68			2b. HOUR 2A M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 3-12-88		6. AGE (In years lost birthday) 80 YRS		
7a. BIRTHPLACE (State or foreign country) W.V.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md		
10. CITY OR TOWN OF DEATH Arbutus			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 922 St. Charles Ave.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE W.V.			13b. COUNTY Dodridge		13c. CITY OR TOWN West Union		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Henderson Stutler			15. MOTHER'S MAIDEN NAME First Middle Last Ida May Kinney					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 232096243-D		17. INFORMANT Address Freda Sahlin 922 St. Charles Ave. 21229			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic CVD DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Two weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Rheumatoid arthritis								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 6/21 , 19 68 , to 12/8 , 19 68 , that (I) (we) last saw the deceased alive on 12/6 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.								
22b. SIGNATURE Harbert J. Levickas, M.D.		22c. DATE SIGNED 12/8/68		22d. ADDRESS 5404 East Drive 21227				
23a. BURIAL A. CREMATION REMOVAL (Specify) Burial		23b. DATE 12-12-68		23c. NAME OF CEMETERY OR CREMATORY West Union Mem. Cem.		23d. LOCATION (City or Town) (County) (State) West Union, W.V.		
24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard 4107 Wilkens Ave. 21229				25a. REC'D BY REG. STRAR DATE DEC 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

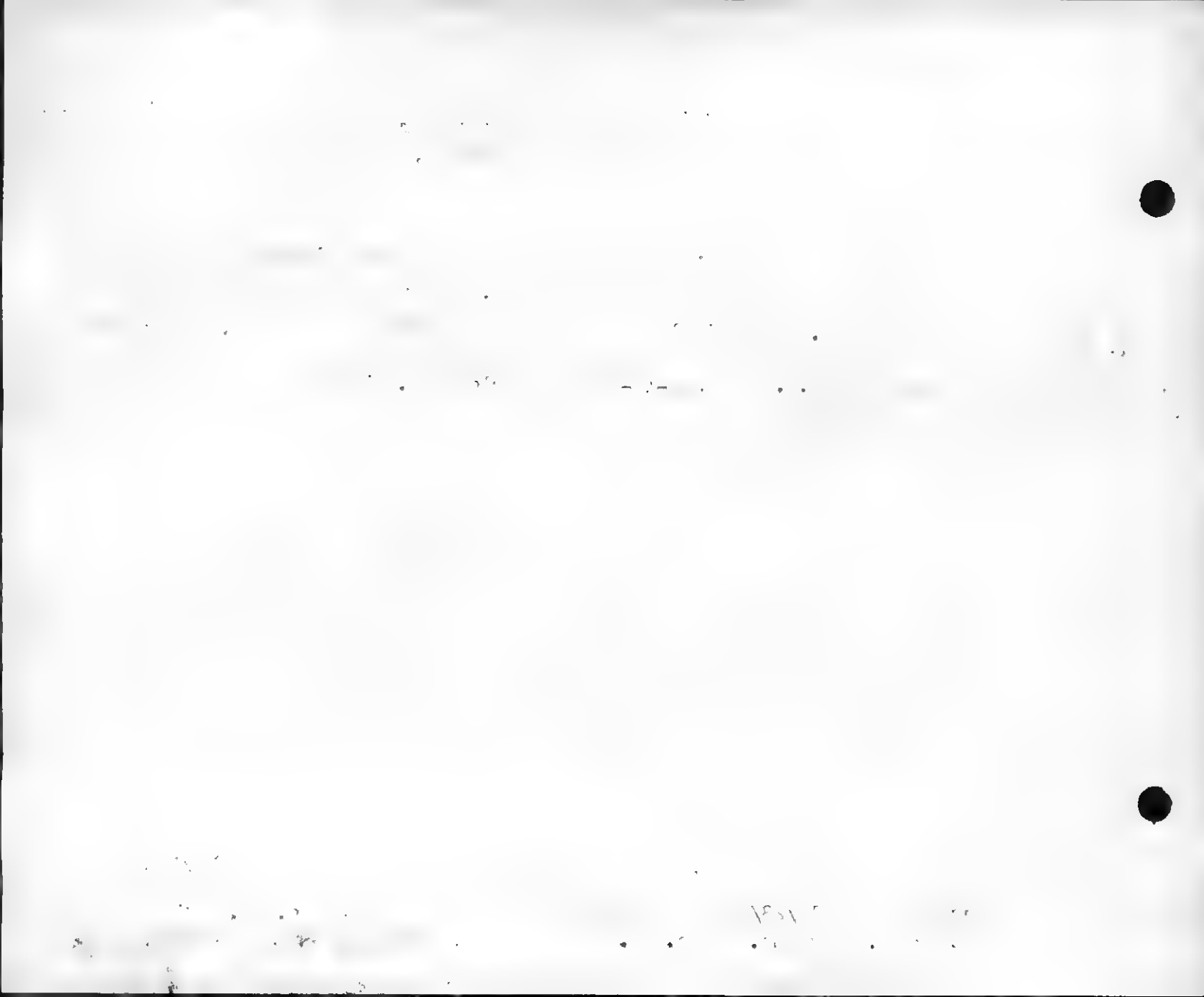
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR 5:30 PM		
FRANCIS JOSEPH LITTLE						December 20 1968					
3 SEX Male		4 RACE White		5 BIRTH September 9, 1922			6 AGE (In years lost day) 46 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Delaware		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore			Md		
10 CITY OR TOWN OF DEATH Towson			11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp tal give street address) St. Joseph's Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Crane Operator Chesapeake Crane			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY, I.M. 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1320 Meridene Drive		
14 FATHER'S NAME John J. Little			15 MOTHER'S MARRIAGE NAME Mable B. Spangler								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>yes</u> (If yes, give branch of service) W.M.2			16b SOCIAL SECURITY NO 218-12-0389		17 INFORMANT Charlotte M. Little			Address Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic lung disease</u> 517.2 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or RFD No. City or Town County State					
22a I certify that (A) (this hospital) attended the deceased from <u>Dec. 19</u> , 19 <u>68</u> , to <u>Decem. 20</u> , 19 <u>68</u> , that (B) (we) last saw the deceased alive on <u>December 20</u> , 19 <u>68</u> , and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above, (D) (we) did (did not) view the body after death											
22b SIGNATURE <i>Samuel C. H. Lee, M.D.</i>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c DATE SIGNED December 20, 1968		
22d. PHYSICIAN'S NAME (Type) Samuel C. H. Lee, M.D.						22e. ADDRESS 7620 York Road, Towson 4, Md.					
23a BURIAL CREMATION, (Specify) Burial			23b DATE 12/23/68		23c NAME OF CEMETERY OR CREMATORY Gardens of Faith			23d LOCATION (City or Town) (County) (State) Balto. Md.			
24 FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md.						25a REGISTRATION DEC 23 1968			25b SIGNATURE <i>James H. Jones</i>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 26 & 27
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17130

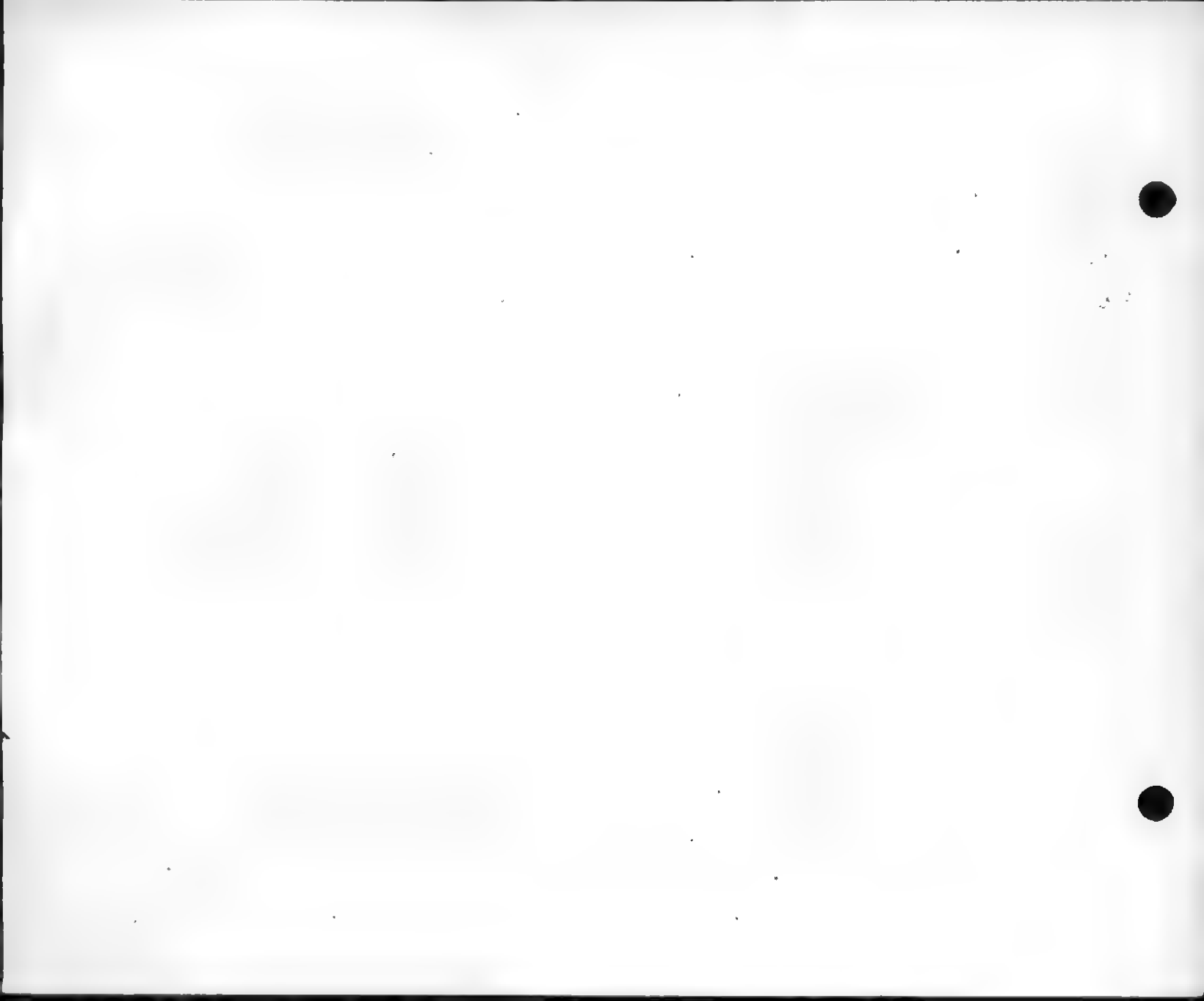
1 DECEASED-NAME (Type or Print) GEORGE B LITTLE SR			2a DATE KNOWN OF DEATH Month 12 Day 23 Year 1968			2b HOUR OF DEATH M 9:15					
3 SEX M	4 RACE W	5 DATE OF BIRTH 12/1/14	6 AGE (In years last birthday) 54 YRS	7a UNDER 1 YEAR MONTHS 0	7b UNDER 24 HRS DAYS 0	7c UNDER 24 HRS HOURS 0	7d UNDER 24 HRS MIN 0	2c DATE PRONOUNCED DEAD Month 12 Day 23 Year 1968	2d HOUR M 2:00		
7a BIRTHPLACE (State or foreign country) MD		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTO.			10 Md.		
10 CITY OR TOWN OF DEATH ESSEX		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 311 NICHOLSON RD			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ELECTRICIAN			12b KIND OF BUSINESS OR INDUSTRY STEEL			
13a USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE MD		13b. COUNTY BALTO.		13c CITY OR TOWN ESSEX		13d. RESIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 311 NICHOLSON RD			
14 FATHER'S NAME First Middle Last WM. LITTLE			15 MOTHER'S MAIDEN NAME First Middle Last ELSIE MOORE								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b SOCIAL SECURITY NO 211-01-3857		17 INFORMANT Helen Little-Wife ADDRESS MARILYN DAHLER ABOVE						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA of LUNG - 1621 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
19a DATE OF OPERATION April 1968			19b CONDITION FOR WHICH OPERATION WAS PERFORMED? Biopsy - Scapular Nodes			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE M.B. DALIS			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 12/23/68
EXAMINER'S NAME (Type) M.B. DALIS			ADDRESS MORRINGTON RD			ADDRESS (Street, city, town, or county)					
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 12/26/68		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.			23d LOCATION (City or Town) BALTO. MD		(County) (State)	
24 FUNERAL DIRECTOR J.G. CONNELLY SONS						ADDRESS 300 MACE		25a. REC'D BY REGISTRAR DEC 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers for pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
1 DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year			2b. HOUR & MIN.				
EMMITT		L.		LITTLETON				December 22			1968 8:00 AM				
3 SEX		4 RACE		5 DATE OF BIRTH				6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
Male		White		8-20-1894				74 YRS							
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH						Md			
Baltimore		U.S.A.				Baltimore									
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore				St. Joseph Hospital				Retired							
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
Maryland						Balto.				2708 N. Howard St. #21218					
4 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last											
?				?											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)				16b. SOCIAL SECURITY NO		17 INFORMANT				Address					
no				215-22-6359		Wife - Vera				same					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Chronic Pulmonary Emphysema, Severe</u>															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
(b) _____															
DUE TO, OR AS A CONSEQUENCE OF															
(c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
5/11															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC)				21f. LOCATION Street or R.F.D. No		City or Town		County State			
22a. I certify that (I) (this hospital) attended the deceased from 12-15-68, 1968, to 12-22, 1968, that (I) (we) last saw the deceased alive on 12-22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.															
22b. SIGNATURE								DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED			
Samuel C. Lee, M.D.												12-22-68			
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS							
Samuel C. Lee, M.D.								7620 York Road, Towson, Md. #21204							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
BURIAL				12/24/68		EAST NEW MARKET				E. NEW MARKET DORCHESTER					
24. FUNERAL DIRECTOR								ADDRESS		25a. DECEASED BY REGISTRAR 1968		25b. REGISTRAR'S SIGNATURE			
Paul E. Howard								3615 Chestnut Ave.		DATE					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 44
45M 1/89

17132

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17132

1 DECEASED NAME (Type or print) Edward		First Middle Last LOEFFLER		2a DATE OF DEATH Month 12 Day 9 Year 1968		2b HOUR 1:05 PM	
3 SEX Male		4 RACE White		5 DATE OF BIRTH March 17, 1877		6 AGE (in years last birthday) 91 YRS	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore,	
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) St. Joseph Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Timonium		12b KIND OF BUSINESS OR INDUSTRY	
13a U.S.A. RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Timonium		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET AND NUMBER 152 Springside Drive		14 FATHER'S NAME First Middle Last 7		15 MOTHER'S MAIDEN NAME First Middle Last 7		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service)	
16b SOCIAL SECURITY NO 219-10-7740		17 INFORMANT Mrs. Edgar E. East,		Address Timonium, Md.		18	
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease with 41 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) congestive failure DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No. City or Town County State			
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/3/ , 19 68 , to 12/9/ , 19 68 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 12/9/ , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Lilia C. Baldonado		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 12/9/68	
22d PHYSICIAN'S NAME (Type) Lilia C. Baldonado, M.D.		22e ADDRESS 7620 York Rd., Towson, Md. 21204					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Dec. 11, 68		23c NAME OF CEMETERY OR CREMATORY Parkwood		23d LOCATION (City or Town) (County) (State) Parkville, Balto Md.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson Md		ADDRESS		25a REC'D BY REGISTRAR DEC 12 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge	



1

17133

MARYLAND STATE DEPARTMENT OF HEALTH

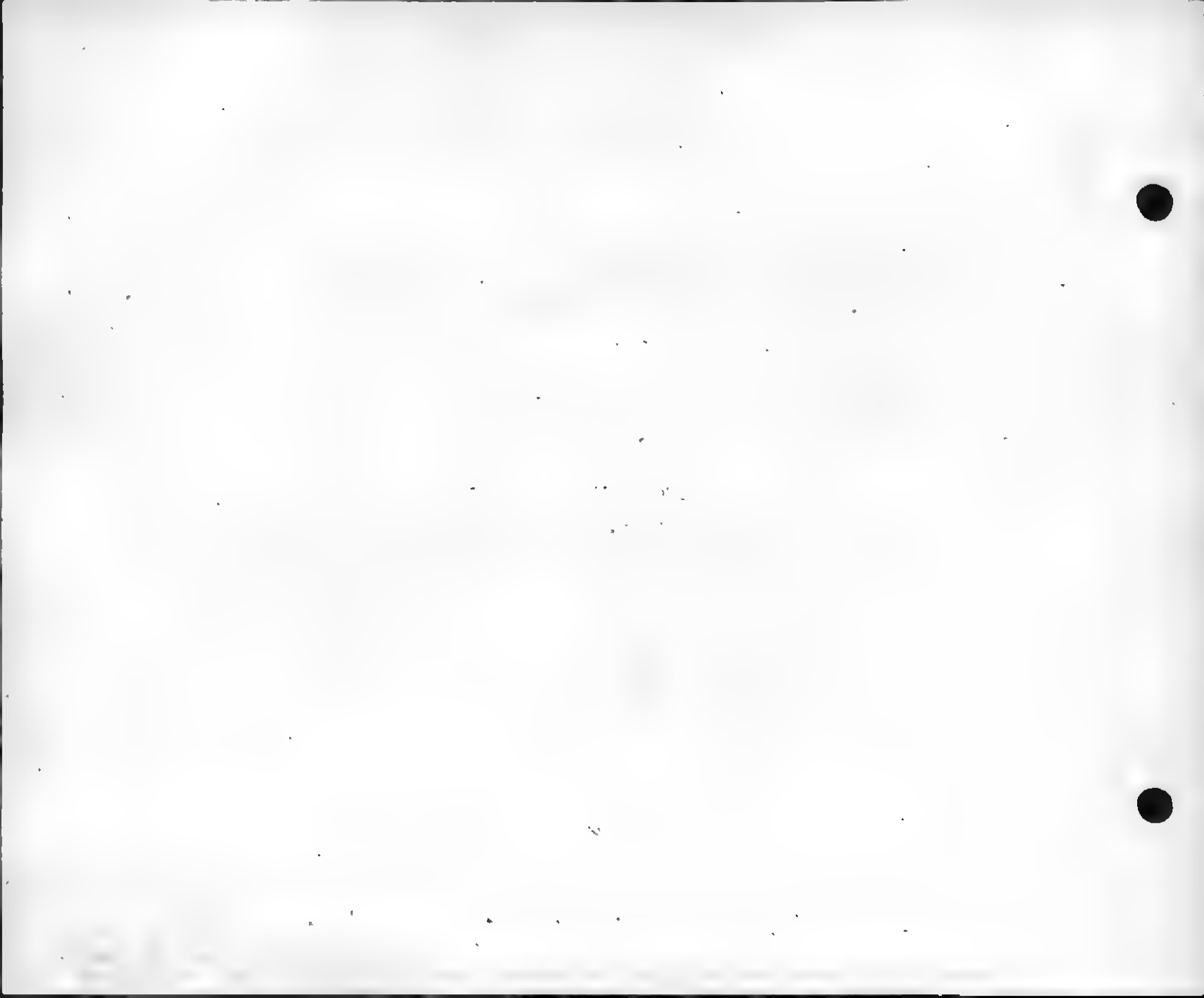
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17133

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) M		First	Middle	Last	2a. DATE OF DEATH Month 12 Day 8 Year 68		2b. HOUR M
3. SEX FEMALE		4. RACE CAU		5. DATE OF BIRTH 12/2/68		6. AGE (In years lost birthday) 76 YRS	IF UNDER 1 YEAR MONTHS 7 DAYS 6
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO. Md.	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GBMC		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY -----		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 2009 East Bank Street		14. FATHER'S NAME First TERRY WILLIAM Middle LOGUE Last LOGUE		15. MOTHER'S MAIDEN NAME First BRENDA Middle KAY Last LOGUE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) PULMONARY DYSPMATURITY DUE TO, OR AS A CONSEQUENCE OF (c) PREMATURITY							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 90 MIN
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12/2 , 19 68 , to 12/8 , 19 68 , that (I) (we) lost saw the deceased alive on 12/8/ 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Michael Bernstein M.D.</i> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/8/68			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS 6701 N. CHARLES STREET			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12/9/68		23c. NAME OF CEMETERY OR CREMATORY Harford Faith		23d. LOCATION (City or Town) (County) (State) Balto Md	
24. FUNERAL DIRECTOR <i>Wm. D. H. H. 322 S. High St</i>		25a. REC'D BY REGISTRAR DATE DEC 20 1968		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 7&8 See birth cert. cert. MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17124

CERTIFICATE OF DEATH

17134

1. DECEASED NAME (Type or print) First Middle Last Baby Girl Lisa Ann Logue			2a. DATE OF DEATH 12 Month 6 Day 68 Year		2b. HOUR 7:55 PM
3 SEX Female	4 RACE White	5. DATE OF BIRTH 12/2/68		6. AGE (in years lost birthday) YRS MONTHS DAYS 4	IF UNDER 1 YEAR HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto Med. Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIM TS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 2009 East Bank Street
14. FATHER'S NAME First Middle Last TERRY WILLIAM LOGUE		15. MOTHER'S MAIDEN NAME First Middle Last BRENDA MAY LOGUE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO	17. INFORMANT Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary insufficiency</u> 7769 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary immaturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) <u>Prematurity of birth</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 12/2/1968, to 12/6/1968, that (I) (we) lost saw the deceased alive on 12/6/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Rudiger Breitenecker, M.D.				22c. DATE SIGNED 12/7/68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS 6701 N. Charles Street	
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE 12/9/68	23c. NAME OF CEMETERY OR CREMATORY Staten Island		23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR Leslie Della Noce		25a. REC'D BY REGISTRAR DATE DEC 20 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



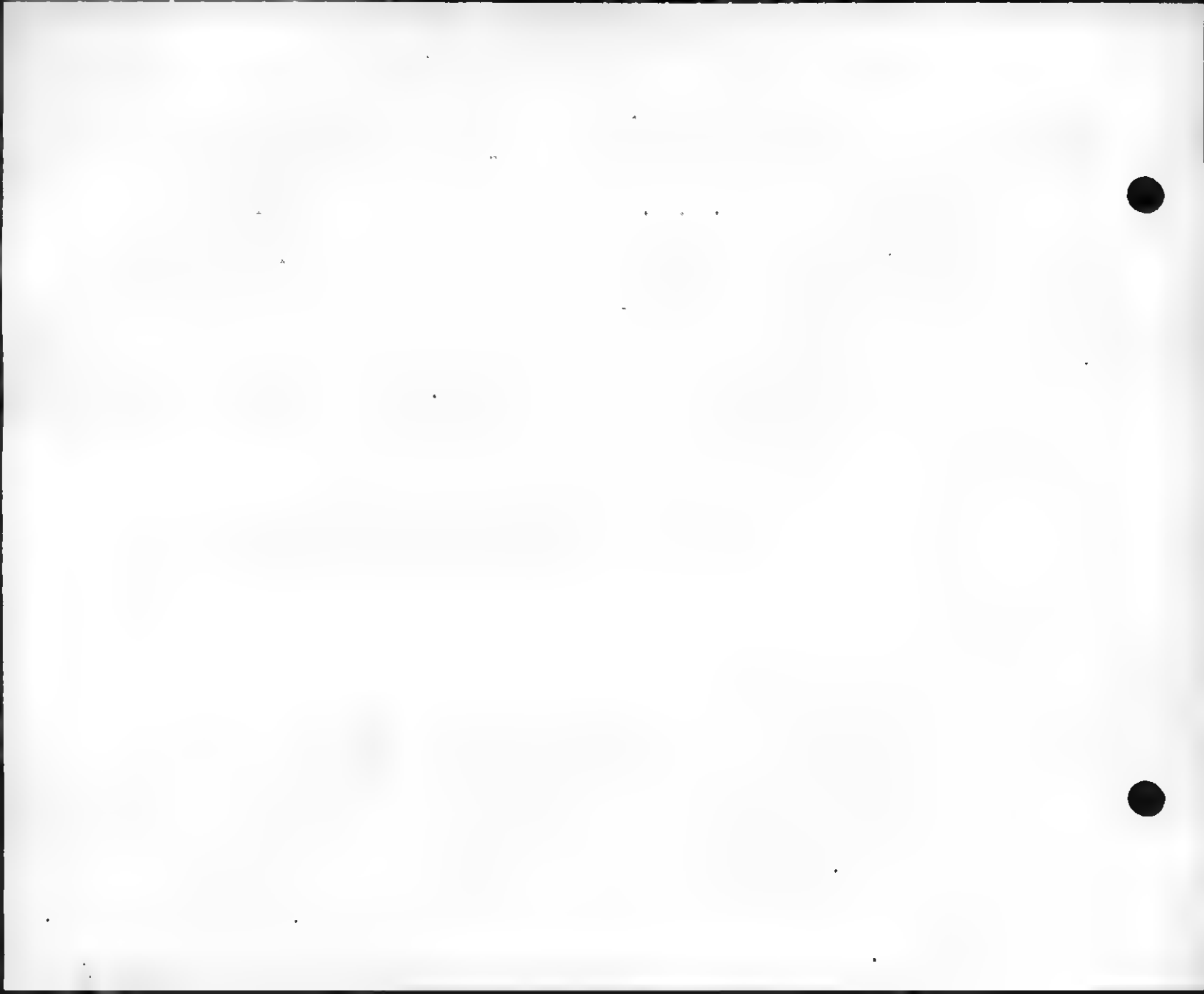
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV

17125										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17135																																							
1 DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last Emil G. Losch										Month Day Year December 23 1968										M																																							
3. SEX M										4. RACE W										5. DATE OF BIRTH 9-21-1896										6. AGE (In years last birthday) 72 YRS.										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.																			
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U. S. A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Baltimore Md.																													
10. CITY OR TOWN OF DEATH Halethorpe										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1808 Mayfield Avenue										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Paint Contractor										12b. KIND OF BUSINESS OR INDUSTRY																													
13a. USLA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b. CITY OR TOWN Baltimore										13c. INSIDE CITY (If YES) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER 1808 Mayfield Avenue																													
14. FATHER'S NAME First Middle Last Carl Losch										15. MOTHER'S MAIDEN NAME First Middle Last Wilamena (Unknown)										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)										16b. SOCIAL SECURITY NO. 218-10-8571										17. INFORMANT Hagerstown, Maryland 21740 Albert L. Losch, Paradise Church Rd. Rt. 6																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crown aneurysm</u> +109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>420</u>																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)										21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC.										21f. LOCAT. ON Street or R.F.D. No City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1960</u> , to <u>Dec 23 1968</u> , that (I) (we) last saw the deceased alive on <u>16 Dec 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <u>William Goodman, M.D.</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <u>24 Dec 68</u>																																							
22d. PHYSICIAN'S NAME (Type) Dr. William Goodman										22e. ADDRESS 1334 Sulphur Spring Road										23a. BURIAL, CREMAT. OR REMOVAL (Specify) Burial										23b. DATE 12-26-68										23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery										23d. LOCAT. ON (City or Town) (County) (State) Balto. City, Baltimore, Md.									
24. FUNERAL DIRECTOR Howard H. Hubbard										ADDRESS 4107 Wilkens Ave. 21229										25a. REC'D BY REGISTRAR DATE DEC 26 1968										25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>																													

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

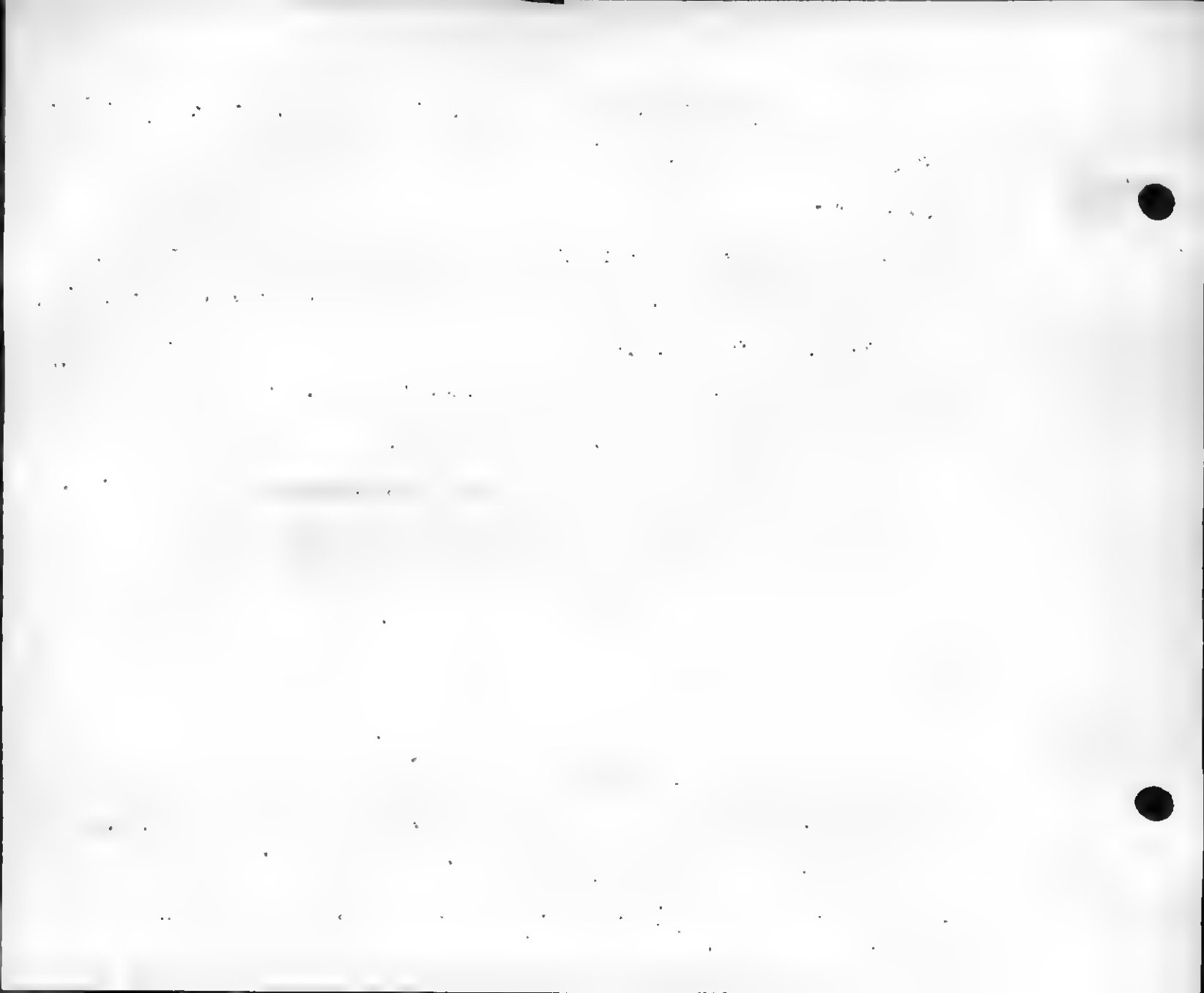
VR A15
30M REV.

17128

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17136

1 DECEASED-NAME (Type or print) BEULAH DEAL LOWDER			2a DATE OF DEATH Month 12 - Day 23 - Year 1968			2b. HOUR 4:30 P.M.				
3 SEX FEMALE		4. RACE CAUCASIAN		5 DATE OF BIRTH AUG. 13, 1903		6 AGE (In years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS — DAYS — HOURS — MIN —		
7a BIRTHPLACE (State or fore- country) N. CAROLINA		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE 21222 Md.				
10. CITY OR TOWN OF DEATH DUNDALK			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3473 LIBERTY PKWY			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SPoolER			12b KIND OF BUSINESS OR INDUSTRY TEXTILE	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD			13b COUNTY BALTIMORE		13c CITY OR TOWN DUNDALK		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 3473 LIBERTY PKWY	
14. FATHER'S NAME First Middle Last EDMOND M. DEAL			15 MOTHER'S MAIDEN NAME First Middle Last GEORGINA R. WALLER							
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 237-01-5396		17 INFORMANT CLIFTON W. LOWDER			Address AS IN 10-11		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) aortic aneurysm, inoperable DUE TO, OR AS A CONSEQUENCE OF (c) with tracheal obstruction									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4-1-1										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 3/7 , 19 62 , to 12/5 , 19 68 , that (I) (was) last saw the deceased alive on 12/5 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.										
22b. SIGNATURE Eugene F. Nevin						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12.24.68		
22d. PHYSICIAN'S NAME (Type) EUGENE F. NEVIN, MD.						22e. ADDRESS 7001 MORNINGTON RD. DUNDALK, MD.				
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b DATE 12/26/68		23c NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL			23d LOCATION (City or Town) (County) (State) BALTIMORE, MD.		
24 FUNERAL DIRECTOR W. Brooks Buckley, Dundalk, Md.						25a REC'D BY REGISTRAR DATE DEC 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



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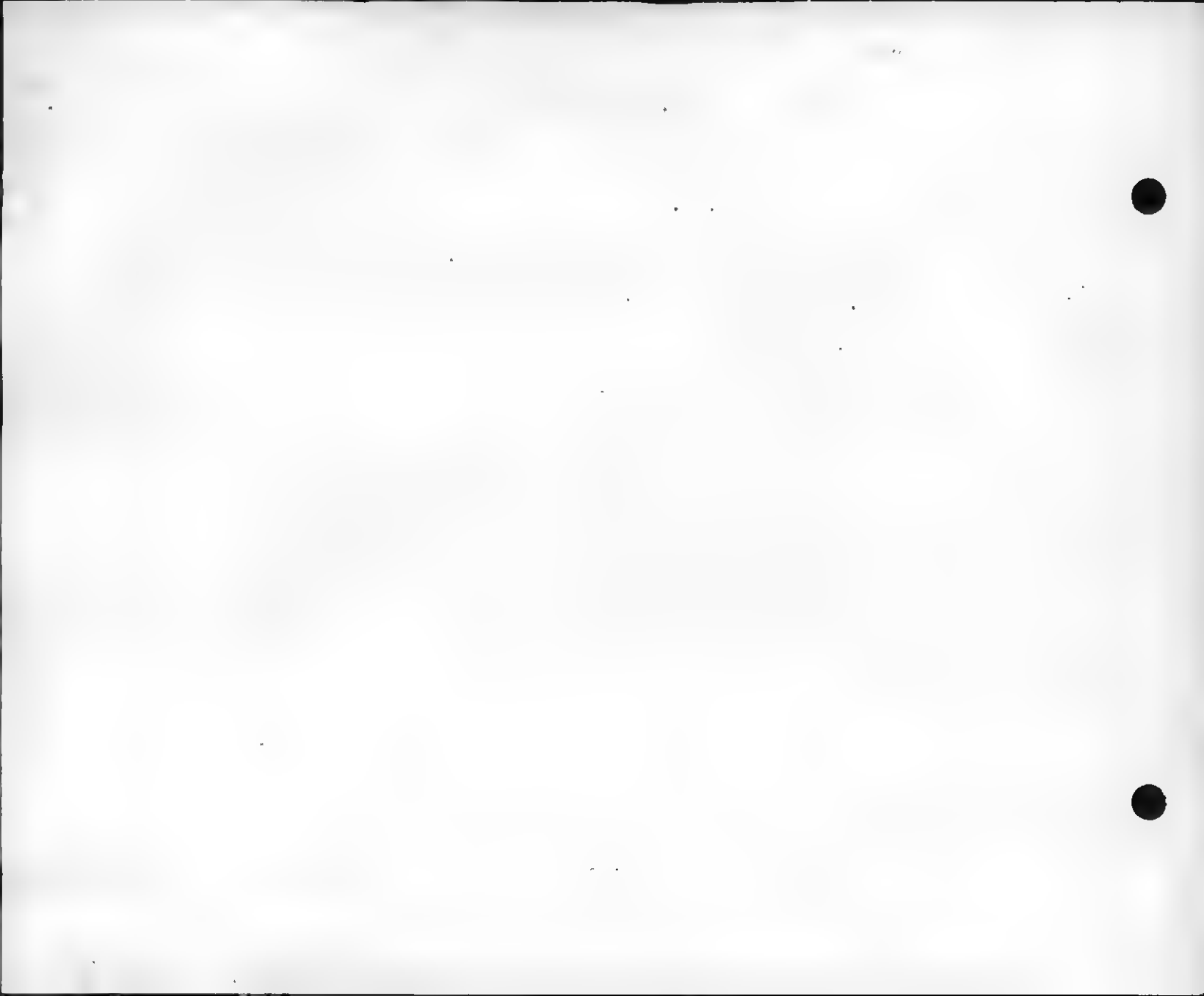
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17127

17137

1. DECEASED-NAME (Type or print) First Middle Last Henry A. Ludwig			2a. DATE OF DEATH Month Day Year December 26, 1968			9. HOUR a. m. 9:05 a.	
3. SEX male		4. RACE white		5. DATE OF BIRTH April 24, 1902		6. AGE (In years last birthday) 66 YRS	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) floor finisher		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Hamilton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 7 Arizona Avenue		14. FATHER'S NAME First Middle Last Conrad H. Ludwig		15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Marie Schmidt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 216-60-9339		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) severe urinary tract infection 2007 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) severe diabetic ulcers and DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Schizophrenia.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from March 31, 1946 to Dec. 26, 1968 , that (I) (we) last saw the deceased alive on Dec. 26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.							
22b. SIGNATURE Rafael H. Marin				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-26-68	
22d. PHYSICIAN'S NAME (Type) Rafael H. Marin, M.D.				22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-1-69		23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore City, Balto. Md.	
24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard 4107 Wilkens Ave., 21229				25a. REC'D BY REGISTRAR DATE DEC 31 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



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VR A15 (4)
30M REV. 1/68

STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS 501 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) DONALD WARD LYON			2a. DATE OF DEATH 12 Month 16 Day 68 Year			2b. HOUR 1 P M			
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH 12-5-61		6 AGE (1 years last birthday) 7 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Balto. Md.		7b CITIZEN OF WHAT COUNTRY? U.S.AA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md			
10 CITY OR TOWN OF DEATH BALTIMORE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREAT BALT MED CENTER		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 301 South Wind Rd.	
14. FATHER'S NAME First Middle Last James A Lyon			15. MOTHER'S MAIDEN NAME First Middle Last Jean Hollingshead						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b SOCIAL SECURITY NO NONE		17. INFORMANT James A. Lyon		Address 301 South Wind Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) MARKED FATTY METAMORPHOSIS OF LIVER WITH DUE TO, OR AS A CONSEQUENCE OF MARKED CEREBRAL EDEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) NONE									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 12/14 , 19 68 , to 12/16 , 19 68 , that (I) (we) last saw the deceased alive on 12/16 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles C. Brown, M.D.				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/16/68			
22d. PHYSICIAN'S NAME (Type) CHARLES C. BROWN, M.D.				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12/18/1968		23c. NAME OF CEMETERY OR CREMATORY 1st Reformed Cent		23d. LOCATION (City or Town) (County) (State) Pompton Plain NJ			
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home WOOD Rd				25a. REC'D BY REGISTRAR DATE DEC 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

NOTES ON THE

D. J. C.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17139

CERTIFICATE OF DEATH

17139

1. DECEASED-NAME (Type or print) AMELIA First Middle Last MAAG			2a. DATE OF DEATH Month 12 Day 18 Year 68 2b. HOUR 9:00 AM	
3. SEX F	4. RACE W	5. DATE OF BIRTH 6/1/88		6. AGE (In years lost birthday) 80 YRS.
7a. BIRTHPLACE (State or foreign country) BA Ho.		7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BA Ho. County Md.
10. CITY OR TOWN OF DEATH Catonville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) retired clerk
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY BA Ho.	13c. CITY OR TOWN BA Ho-28	13d. SIDE CITY L.M. 157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Middle Last August - MAAG		15. MOTHER'S MAIDEN NAME First Middle Last Hentelman ("athilda)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO 212-36-2662	17. INFORMANT Address BROTHER-6114 A-5 Edmond. AVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident 4369 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Cerebral Arteriosclerosis (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs Year				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Previous CVA's.				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State
22a. I certify that (I) (the hospital) attended the deceased from Jan , 19 63 , to Dec 10 , 19 68 , that (I) (we) last saw the deceased alive on 12/17 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE James J. Nolan		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/19/68
22d. PHYSICIAN'S NAME (Type) Dr. James J. Nolan		22e. ADDRESS 1 Mallow Hill Road		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/21/68	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	
23d. LOCATION (City or Town) Baltimore, Md.		(County) (State)		
24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229		ADDRESS		25a. DEC. BY REGISTRAR DEC 23 1968
25b. REGISTRAR'S SIGNATURE James J. Nolan				



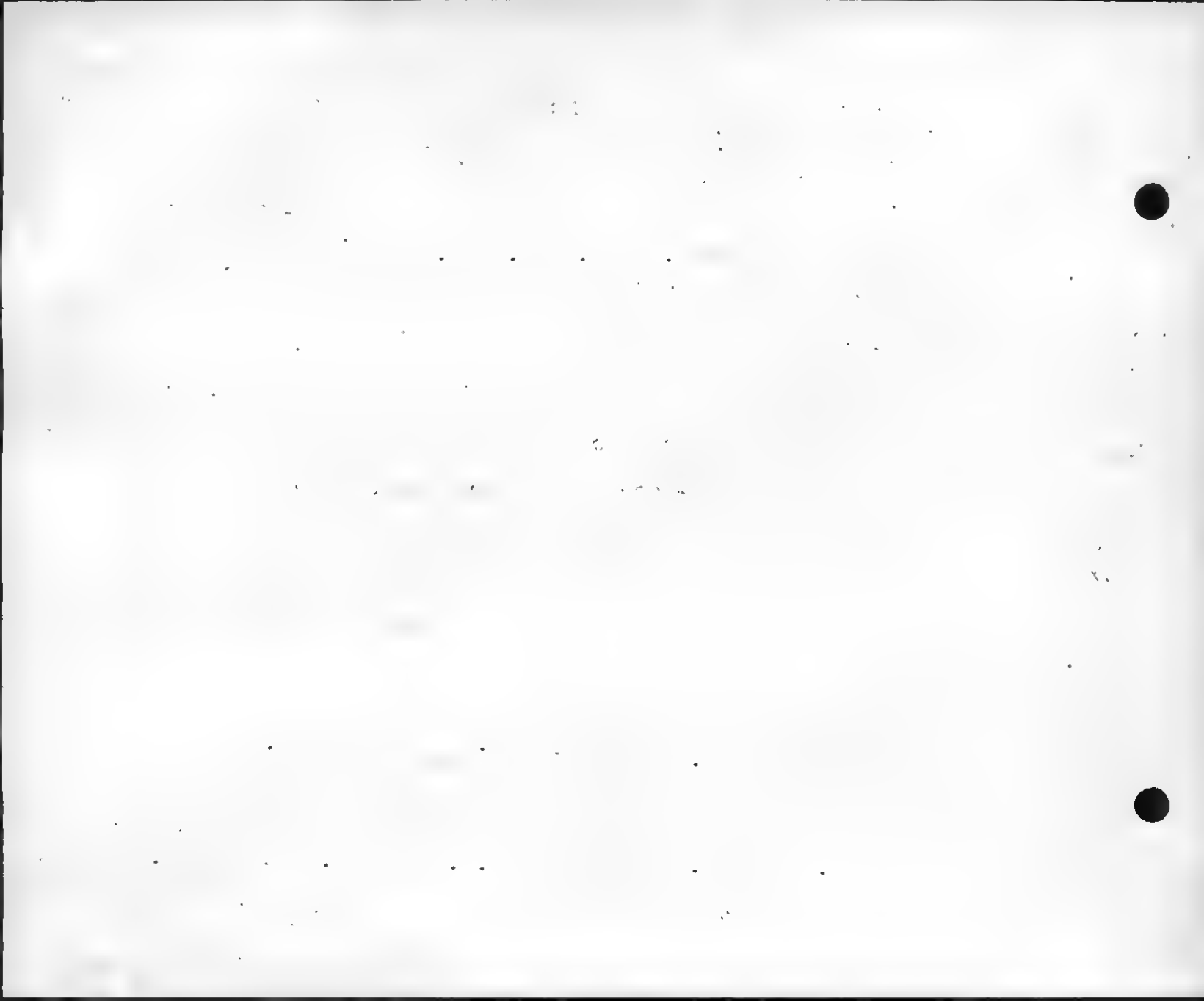
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) James M MacBrayne		2a. DATE OF DEATH 12 Month 15 Day 68 Year		2b. HOUR 8 00 M	
3. SEX Male	4. RACE W	5. DATE OF BIRTH 11/13/1889		6. AGE (In years lost birthday) 79 YRS.	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Scotland	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore County Md		
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Great. Balt. Med. Cen.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md	13b. COUNTY Balto	13c. CITY OR TOWN Balto	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 7801 Beverly Rd	
14. FATHER'S NAME First Middle Last Unknown		15. MOTHER'S MAIDEN NAME First Middle Last Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address Mrs. Hans Odin 7801 Beverly Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction and CVA DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that he (this hospital) attended the deceased from Dec. 4 , 19 68 , to Dec. 15 , 19 68 , that he (we) lost saw the deceased alive on Dec. 15 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) not view the body after death.					
22b. SIGNATURE Barry R. Friedlander MD		DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/15/68	
22d. PHYSICIAN'S NAME (Type) Dr. Barry R. Friedlander M.D.		22e. ADDRESS 6701 N. Charles St. 21204			
23a. SUBAL CREMATION <input type="checkbox"/> BURIAL <input checked="" type="checkbox"/>		23b. DATE 12/17/68		23c. NAME OF CEMETERY OR CREMATORY Greenmount	
23d. LOCATION (City or Town) Balto		(County)		(State)	
24. FUNERAL DIRECTOR Al Neumann		ADDRESS 6067 Harford Rd		25a. REC'D BY REGISTRAR DEC 20 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

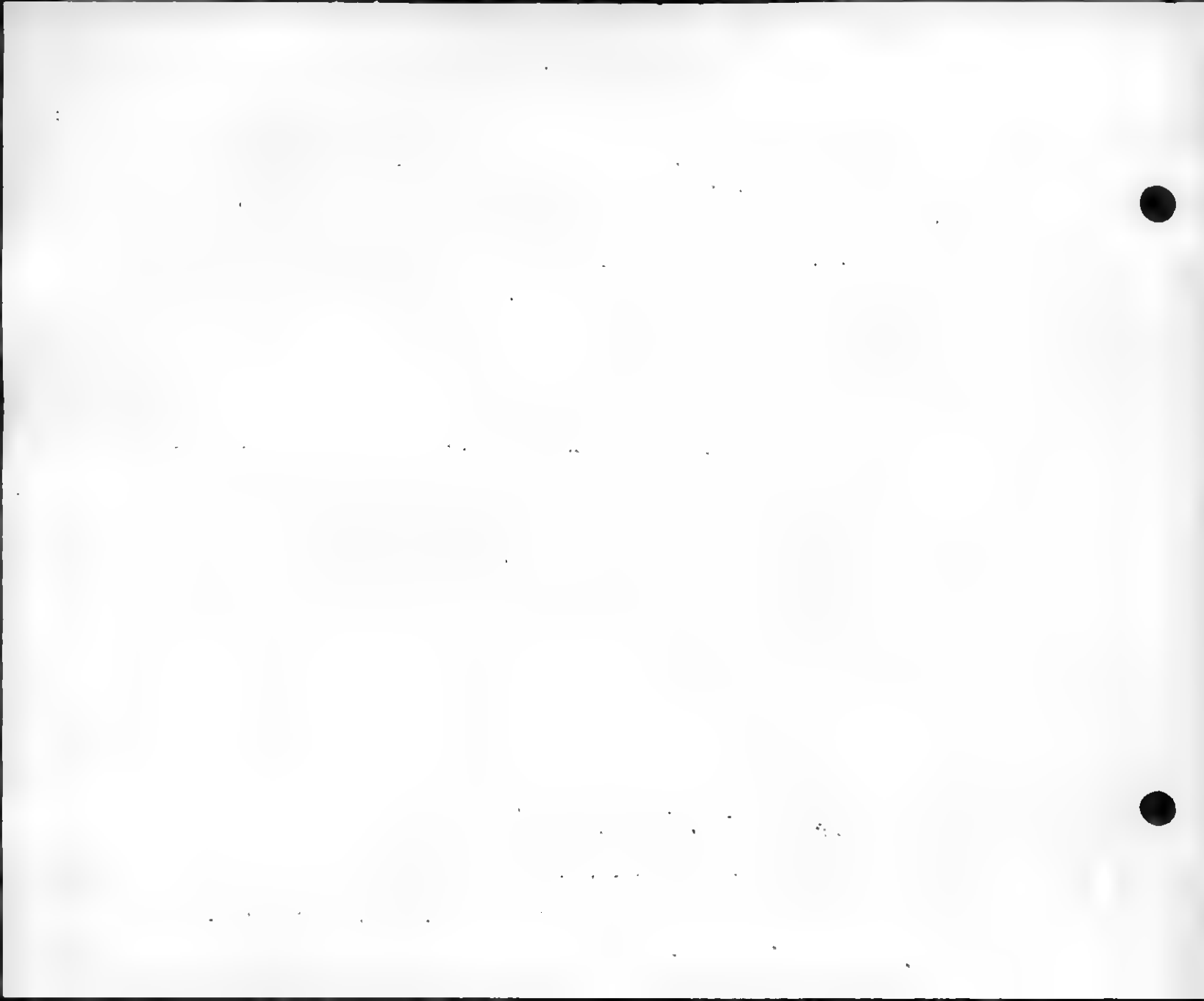


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<div>17131</div> <div>1/2/69</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Information taken from birth cert.</div> <div>CERTIFICATE OF DEATH</div> <div>17141</div>													
1 DECEASED NAME (Type or print)			First M. d. d. l. e MALE "A"			Last MACEY			2a DATE OF DEATH 12 Month 29 Day 68 Year			2b HOUR P 11:45 M	
3 SEX Male			4 RACE Cau.			5. DATE OF BIRTH 12/29/68			6. AGE (In years last birthday) YRS			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.			7b CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore, Md				
10 CITY OR TOWN OF DEATH Baltimore, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GBMC			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b COUNTY Baltimore			13c CITY OR TOWN Baltimore			13d INSIDE CITY - IN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER 3230 Rolling Road	
14 FATHER'S NAME First Middle Last Horace Thomas Macey, III			15. MOTHER'S MAIDEN NAME First Middle Last Kathleen Marie Schlining			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO (If yes give war or dates of service)			17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe generalized edema - etiology undeter-</u> <u>7826</u> DUE TO, OR AS A CONSEQUENCE OF <u>mined.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>7826</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>12/29</u> , 19 <u>68</u> , to <u>12/29</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>12/29</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE <u>Charles C Brown, MD</u>			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c DATE SIGNED 12/29/68				
22d. PHYSICIAN'S NAME (Type)			Charles C. Brown, M.D.			22e ADDRESS Greater Baltimore Medical Center							
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE 12/31/68			23c NAME OF CEMETERY OR CREMATORY Greater Balto. Med. Cen.			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland				
24 FUNERAL DIRECTOR <u>Charles C Brown, MD</u>			ADDRESS			25a. REC'D BY REGISTRAR DATE JAN 8 1969			25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

MEDICAL CERTIFICATION

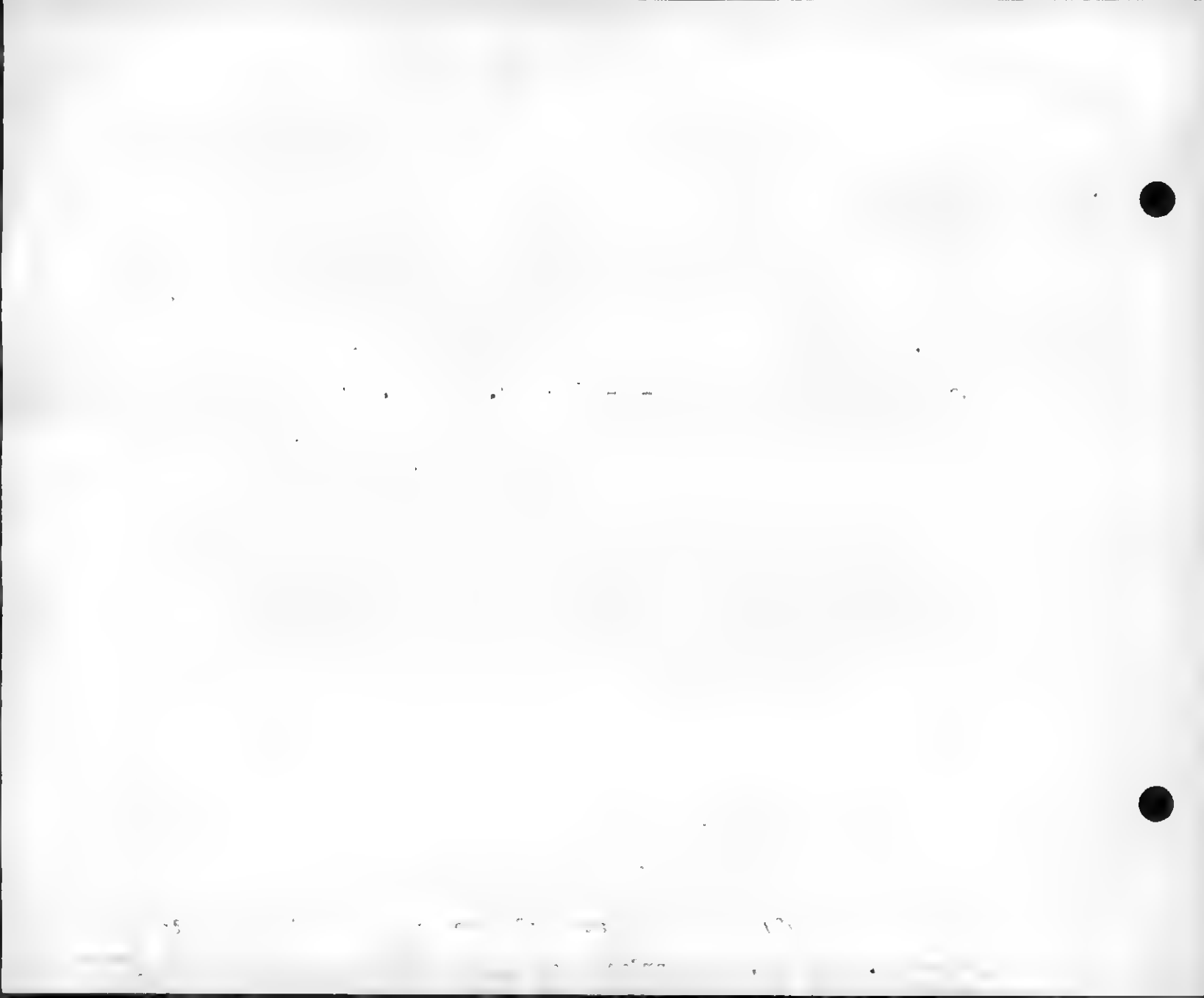


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div style="display: flex; justify-content: space-between;"> 17142 MARYLAND STATE DEPARTMENT OF HEALTH </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div> 17142																	
1. DECEASED-NAME (Type or print)			First Marie			Middle A.			Last Madsen			2a. DATE OF DEATH Month 12 Day 29 Year 1968			2b. HOUR 3:15 P.M.		
3 SEX Female			4 RACE White			5 DATE OF BIRTH April 14, 1891			6 AGE (In years lost birthday) 77 YRS.			IF UNDER 1 YEAR MONTHS 77 DAYS 77		IF UNDER 24 HRS HOURS 77 MIN 77			
7a. BIRTHPLACE (State or foreign country) Baltimore			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore, Md								
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 2402 Lake Ave.					
14. FATHER'S NAME First John N. Suwalski						Middle 						Last 					
15. MOTHER'S MAIDEN NAME First Margaret Krahn						Middle Kraning						Last 					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 215-05-9877B			17. INFORMANT Mr. Peter J. Masden			Address Same								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema secondary to arteriosclerotic cardiovascular disease																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																	
DUE TO, OR AS A CONSEQUENCE OF																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
422																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (A) (this hospital) attended the deceased from 12/29/1968 , to 12/29/1968 , that (A) (we) last saw the deceased alive on 12/29/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Tomboe Camilo															22c. DATE SIGNED 12/29/68		
22d. PHYSICIAN'S NAME (Type) Camilo Tombac, M.D.			22e. ADDRESS 7620 York Rd., Towson, Md. 21204														
23a. BURIAL OR CREMATION, REMOVAL (Specify) Burial			23b. DATE 1/2/69			23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore Maryland								
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. 5305 Harford Road 21214																	
25a. REC'D BY REGISTRAR JAN 2 1969															25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Katie Manning					December	11	1968	6:50AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN.	
Female	Negro	Dec. 18, 1881		86 YRS.				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Unknown	U.S.A.			Baltimore Md				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Peisterstown	Baltimore Nursing Home		Domestic		Private Homes			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER				
Maryland		Baltimore		Unknown				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
Thomas Menning					Martha Jones			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown) (If yes give war or dates of service))		16b. SOCIAL SECURITY NO		17. INFORMANT Address				
Unknown		217-62-0322		Balto. City Welfare Dept. Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Constrictive Heart Failure - Chronic</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerosis - generalized</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Brain Syndrome</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> <u>Years</u> <u>Years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>July 2, 1967</u> to <u>December 11, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 10</u> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>C. E. McWilliams</u>		22c. DATE SIGNED <u>12-11-68</u>		22d. PHYSICIAN'S NAME (Type) C. E. McWilliams				
22e. ADDRESS <u>11908 Peisterstown Rd. Peisterstown Md.</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		Dec. 13, 1968		Mt. Auburn Cemetery		Baltimore, Maryland.		
24. FUNERAL DIRECTOR <u>H. J. Ebhardt</u>		ADDRESS Owings Mills, Md.		25a. REC'D BY REGISTRAR DATE <u>DEC 16 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in the space provided. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

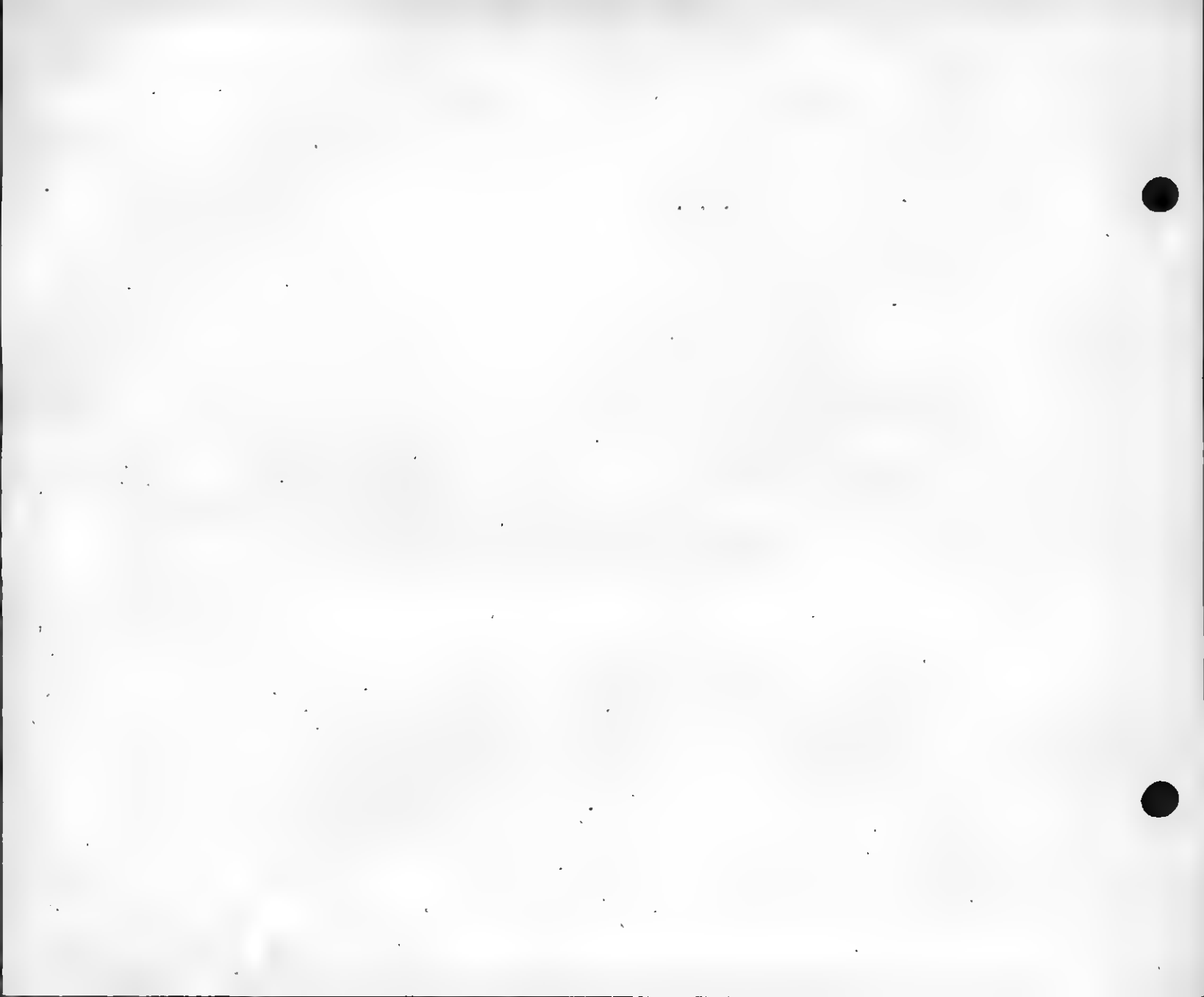
17134

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17144

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR					
Karan			Vicari			Marshall			December 22, 1968			6:15 P.M.		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN	2c DATE PRONOUNCED DEAD			2d HOUR			
Female	White	1-21-68	11	1				December 22, 1968			6:15 P.M.			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH					
Maryland			U.S.A.						Baltimore			Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY					
Towson			St. Joseph Hospital											
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER		
Maryland			Baltimore			Parkville						1311 Kenton Rd.-21234		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME											
Stanley			Marshall Jr.			Mary						Marshall		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)									Crushing Injury To Brain Stem					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									2 Days					
DUE TO, OR AS A CONSEQUENCE OF (b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
4000														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)								
			12:00 A.M. December 19, 1968			Ran Kiddie Card down 115 steps								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No.								
			Home			1311 Kenton Rd 21234								
22a I certify that I took charge of the remains described above, he died an Autopsy <input type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED					
Charles F. O'Donnell			Charles F. O'Donnell, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			12/22/68					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
						ADDRESS (Street, city, town, or county)								
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)					
BURIAL			DEC. 23, 1968			HOLY ROSARY CEM.			PUNDALK, BALTO. CO., MD.					
24 FUNERAL DIRECTOR			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE								
John Burns' Sons, Towson, Md.			DEC 31 1968			Charles Judge								

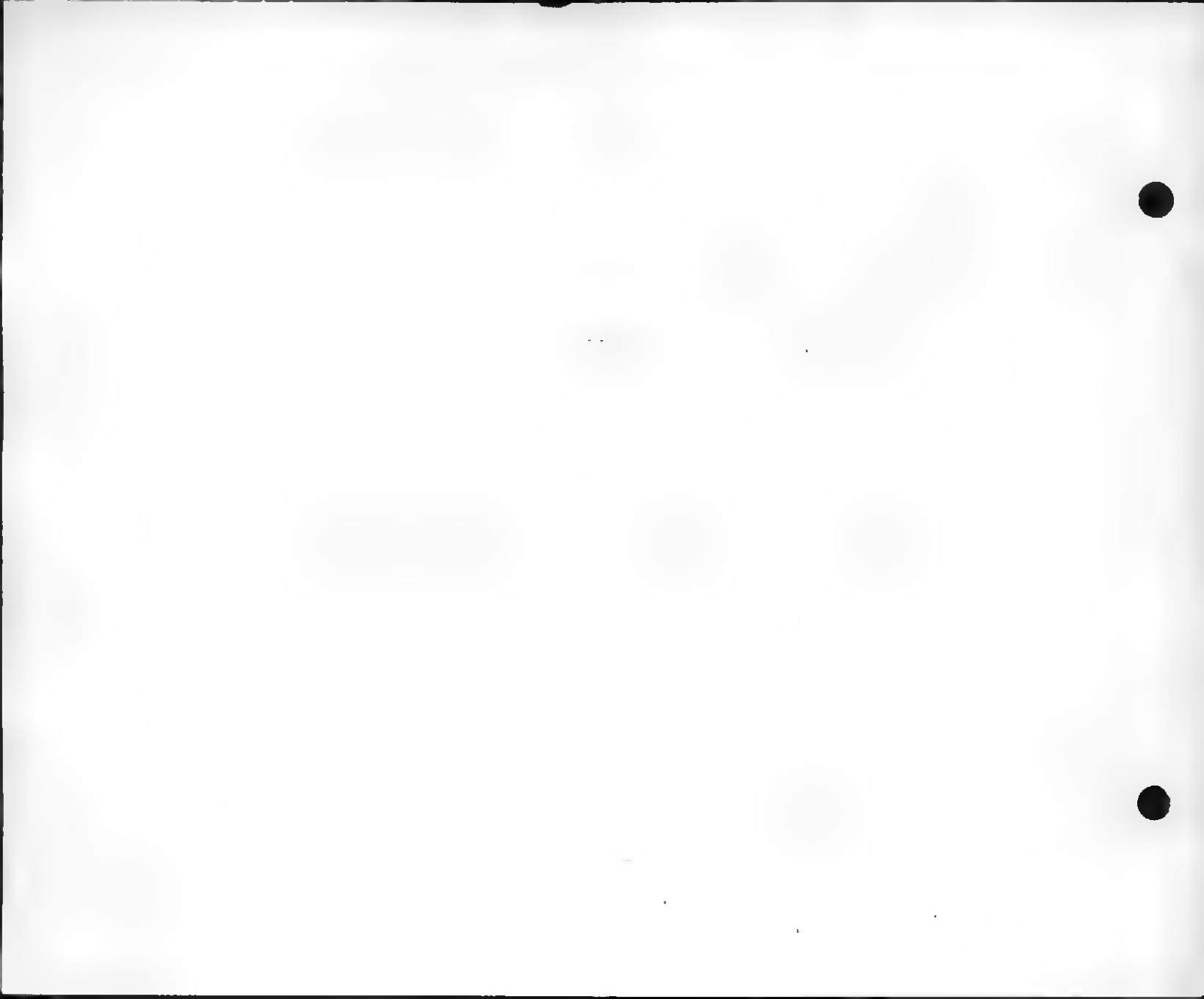


TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

230
24

17145

1. DECEASED NAME (Type or print)		First Sharon		Middle Lynn		Last MARSHALL		2a. DATE OF DEATH		Month 12		Day 9		Year 1968		2b. HOUR 9:30 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 12-9-1968		6. AGE (In years as of birthday)		7. UNDER 1 YEAR MONTHS		8. DAYS		9. UNDER 24 HRS. HOURS		10. MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore,											
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY											
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1311 Kenton Rd.									
14. FATHER'S NAME		First Stanley		Middle Marshall		Last		15. MOTHER'S MAIDEN NAME		First Mary		Middle Vicari		Last Noppenberger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. None		17. INFORMANT Family records -		Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> <u>777X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>776X</u>																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State													
22a. I certify that <u>NO</u> (this hospital) attended the deceased from <u>12/9/</u> , 19 <u>68</u> , to <u>12/9/</u> , 19 <u>68</u> , that <u>NO</u> (we) last saw the deceased alive on <u>12/9/</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Imelda Salanio</u>		22c. DATE SIGNED 12/9/68		22d. PHYSICIAN'S NAME (Type) Imelda Salanio, M.D.		22e. ADDRESS 7620 York Rd., Towson, Md. 21204											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 11, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>											
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 11 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>													



17126

CERTIFICATE OF DEATH

17146

1. DECEASED NAME (Type or print) M A R Y		First M A R Y		Middle M A R T I N		Last		2a DATE OF DEATH December 28, 1968		2b HOUR 4:00 P.M.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH May 18, 1893		6 AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Lithuania		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore				Md.	
10. CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 710 Charing Cross Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Tailor		12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Catonsville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 710 Charing Cross Road			
14. FATHER'S NAME First Middle Last Unknown				15. MOTHER'S MAIDEN NAME First Middle Last Magdalen Rimkus							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO.		17. INFORMANT Miss Dorothy Martin, 710 Charing Cross Rd.		Address 21229					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cholesterol DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Arteriosclerosis											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4438											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 8-21-1967 , to Dec 28, 1968 , that (I) (we) last saw the deceased alive on Dec 31, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Harry L. Knipp, MD		22c DATE SIGNED 1-2-69		22d PHYSICIAN'S NAME (Type) Dr. Harry L. Knipp		22e ADDRESS 4116 Edmondson Avenue, Balto., Md.					
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 1-3-1968		23c NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24 FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave.		24a ADDRESS 21229		25a REC'D BY REGISTRAR JAN 6 1969		25b REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 141
45M 169

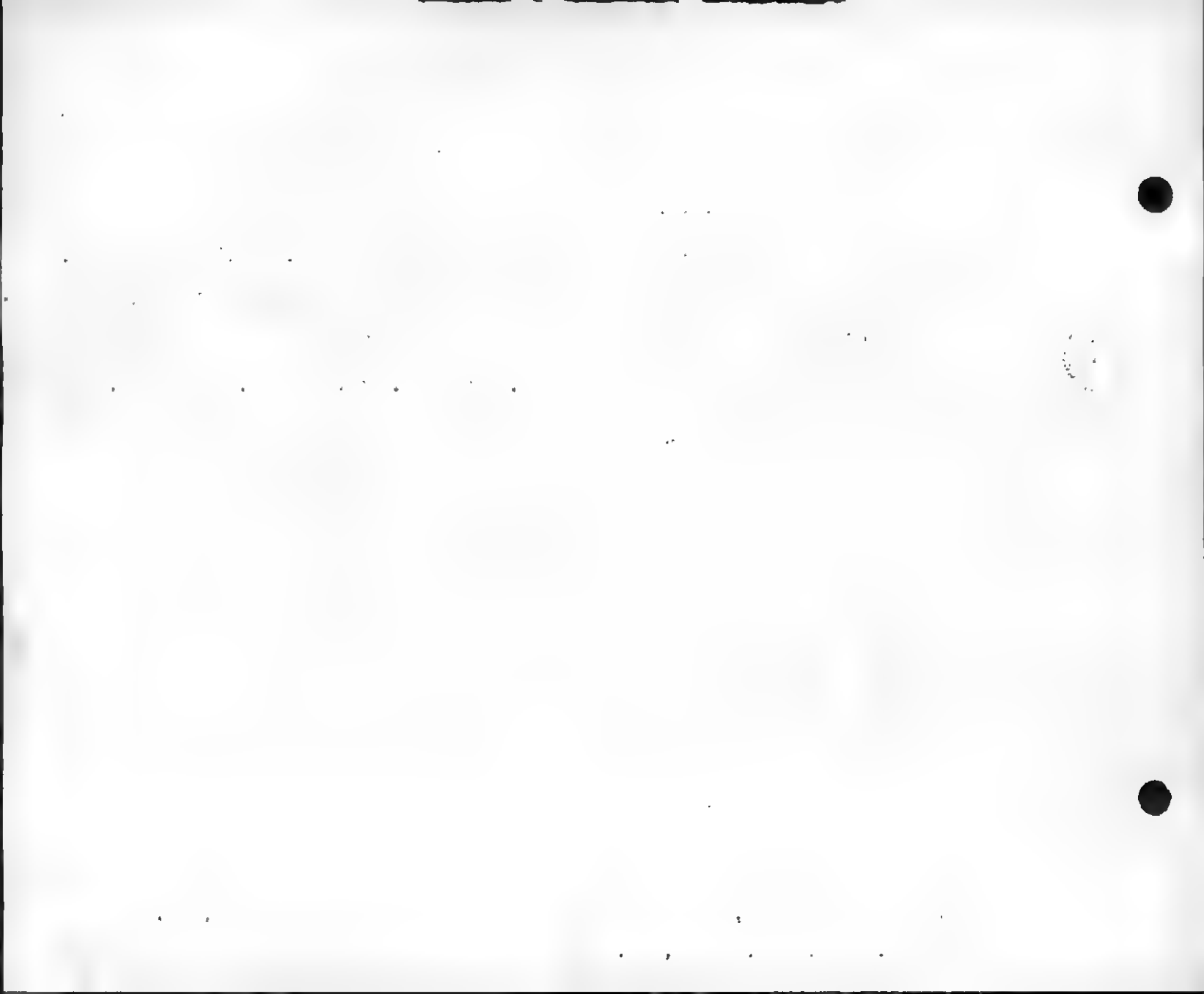
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17137

17147

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR	
CHARLES WILBER MAUSE					December 14 1968		7.40PM	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male	White		5-22-13		55 YRS			
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
Maryland	U.S.A.				Baltimore			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Towson		St. Joseph Hospital		Radar Tech. Bendix Radio Corp.				
13a USUAL RESIDENCE (Where deceased lived on)		13b CITY OR TOWN		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
STATE Maryland		Baltimore				921 Wilcox Wilcox Ct.		
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME		Address				
Charles Mouse		Georgia Zollner		Mr. Laurie C. Mause, 821 N. Glover St. 21205				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT				
No				Mr. Laurie C. Mause, 821 N. Glover St. 21205				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gastro Intestinal Hemorrhage								
DUE TO, OR AS A CONSEQUENCE OF (b) Peptic Ulcer								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Possible Cerebral Hemorrhage								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET, FACTORY OFFICE BUILDING ETC)		21f LOCATION Street or RFD No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 11-21-1968, to 12-14-1968, that (I) (we) last saw the deceased alive on 12-14-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE		22c DATE SIGNED		22e ADDRESS				
Camilo Z. Tomboc		12-14-68		7620 York Rd., Towson, Md. 21204				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. ADDRESS				
Camilo Z. Tomboc MD.		7620 York Rd., Towson, Md. 21204		7620 York Rd., Towson, Md. 21204				
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		12/19/68.		Oak Lawn Cemetery		Baltimore, Md.		
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		DATE		
Leonard J. Ruck, Inc. Balto. Md. 21214		DEC 16 1968		Charles Judge				



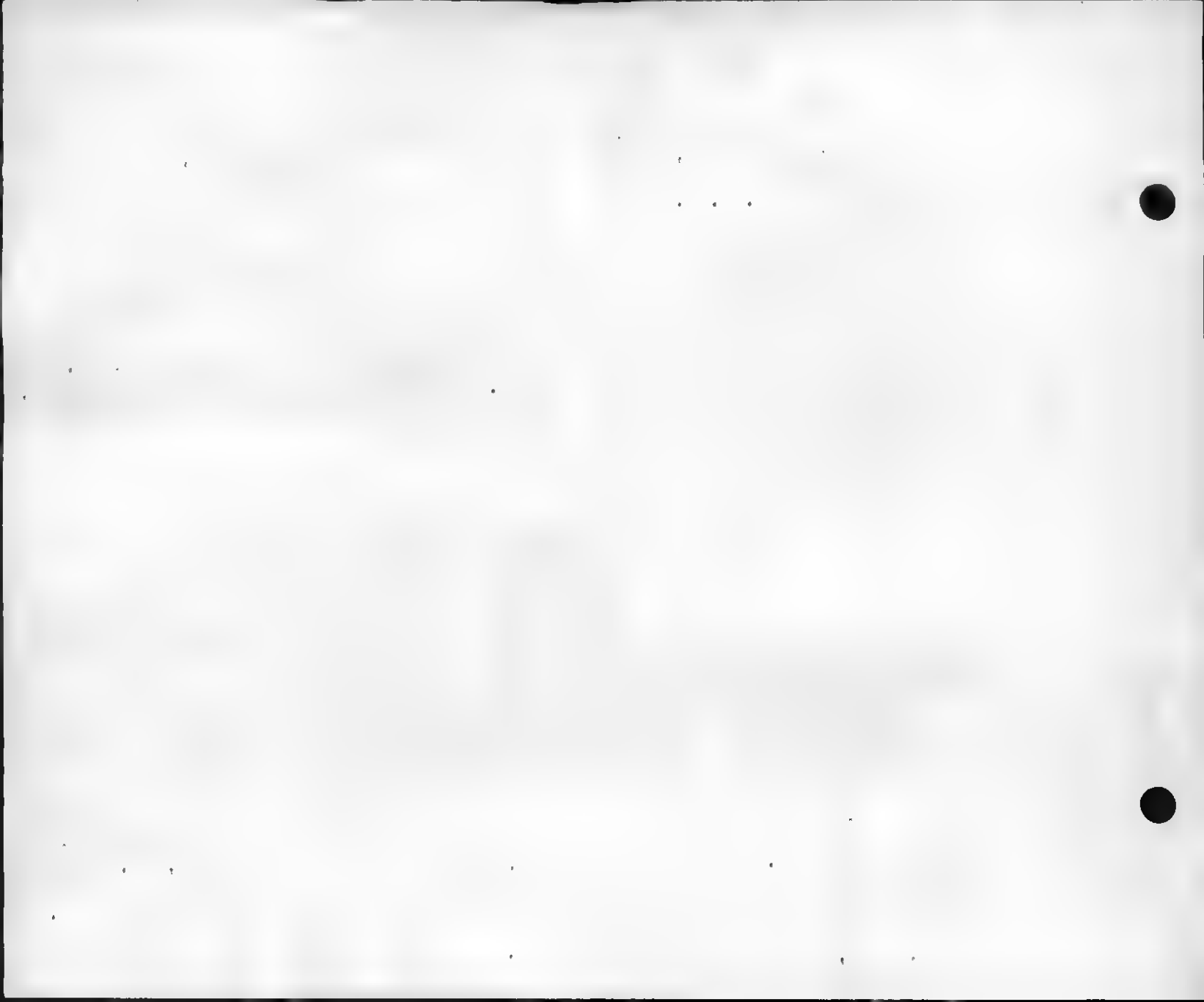
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER
necessary, please execute the certificate of death and return it to the funeral director. Page 4 should be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-instit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MIDDLE										
17180		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201						17149		
1 DECEASED NAME (Type or print) OTIS OTIS LEE				Middle		Last		2a DATE OF DEATH DEC. Month 9 Day 1968		2b HOUR M
3 SEX male		4 RACE Cau.		5 DATE OF BIRTH Oct. 13, 1922		6 AGE (In years lost birthday) 46 YRS.		7 UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) Tenn.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		Md.		
10 CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Tec. Eng.		12b KIND OF BUSINESS OR INDUSTRY T.V.				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c CITY OR TOWN Phoenix		13d INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Princess Anne Way		
14. FATHER'S NAME First Middle Last Charles McConkey				15. MOTHER'S MAIDEN NAME First Middle Last Mary A. Shaley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. 1942-1946		17. INFORMANT Elizabeth McConkey		Address Same as # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest										-
4109 Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction										-
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary atherosclerosis										10 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7201										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from Nov 19 59, to Oct 19 68, that (I) (we) last saw the deceased alive on 24 Oct 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Abraham Genecin				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12/9/68		
22d. PHYSICIAN'S NAME (Type) Abraham Genecin, M.D.				22e. ADDRESS 611 1/2 Park Ave.						
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 12-11-1968		23c NAME OF CEMETERY OR CREMATORY Floral Gardens		23d. LOCATION (City or Town) High Point, N. C.		(County)		(State)
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road, Towson, Md 21204				ADDRESS		25a. RECD BY REGISTRAR DATE DEC 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

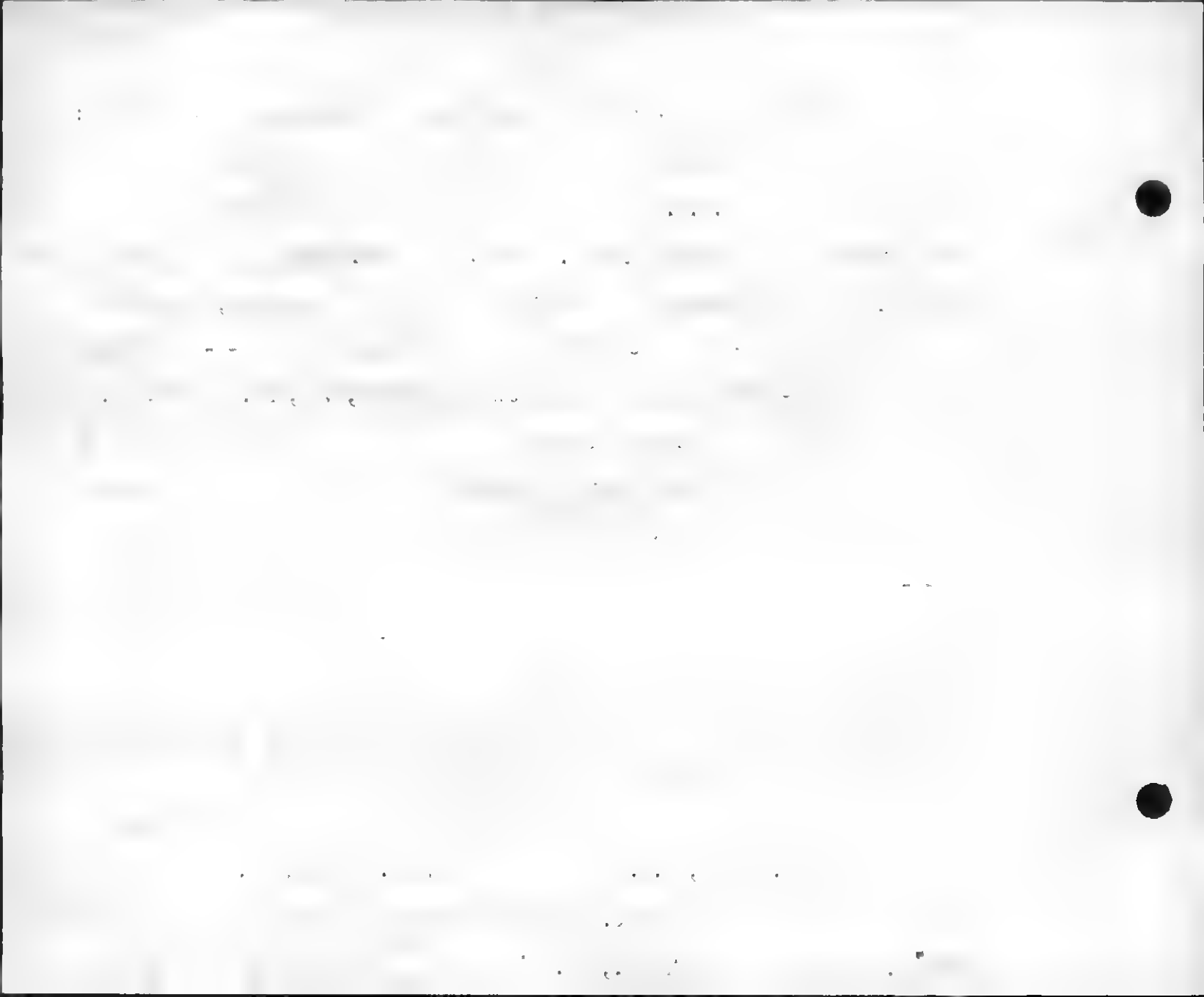


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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year			2b. HOUR	
DENNIS			JOHN		McCORMACK		DECEMBER 30, 1968			8:30 p M			
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS	
MALE			WHITE			6/26/04			64 YRS				
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH				
SCOTLAND			U.S.A.						BALTIMORE			Md	
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USLA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
FORT HOWARD			VETERANS ADMIN. HOSPITAL			CARPENTER			CONSTRUCTION				
3a USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
MARYLAND			BALTIMORE			Fort Howard BALTIMORE						Box 280A, Route 10	
14 FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last	
JOHN			-		-		McCORMACK		MARGARET			- - McDUGALL	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT			Address				
YES			1922 - 1925			213 07 51 04			CLINICAL RECORDS, VAH, FT. HOWARD, MD.				
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST												HOURS	
DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION												UNKNOWN	
CONDITIONS, if any, which gave rise to immediate cause (a) stating the underlying cause last (c) - -													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building etc)			21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (this hospital) attended the deceased from DEC 6, 1968, to DEC 30, 1968, that (we) last saw the deceased alive on DEC 30, 1968, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.													
22b. SIGNATURE			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED				
PETER V. JUVAN									12/30/68				
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS										
PETER V. JUVAN, M.D.			VAH, FT. HOWARD, MD.										
23a. BURIAL CREMATON, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
BURIAL			1/13/69			BALTO. NATIONAL CEMETERY			BALTIMORE, MARYLAND				
24. FUNERAL DIRECTOR			ADDRESS			25a. REG. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
JOHN J. DUDA			7922 WISE AVE. BALTO., MD.			JAN 2 1969			Charles Judge				

VAH 12/30/68
45N 12/30/68



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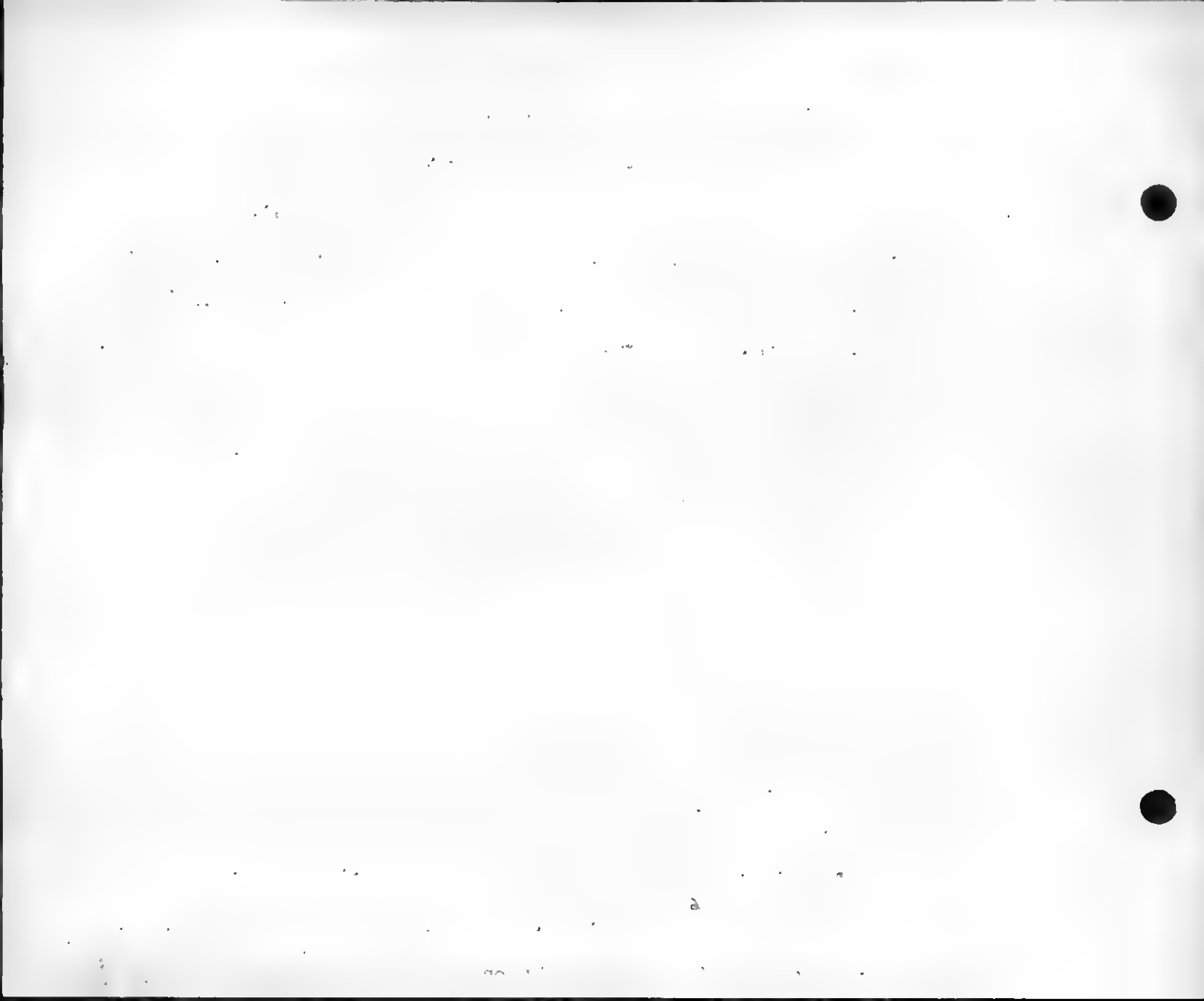
VR A15 (4)
30M REV. 1/68

17151

17151

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last Harold Arthur Mc Cormick			2a DATE OF DEATH Month Day Year 12 29 1968			2b HOUR 5A M			
3 SEX Male		4 RACE White		5 DATE OF BIRTH 1-9-1906		6 AGE (In years lost birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Kansas		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Balto. Md			
10. CITY OR TOWN OF DEATH Phoenix		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Phoenix Rd.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Manufacture's Rep.		12b. KIND OF BUSINESS OR INDUSTRY Self			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b COUNTY Balto.		13c. CITY OR TOWN Phoenix		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Phoenix Rd. (Rural)	
14 FATHER'S NAME First Middle Last Wm. Arthur Mc Cormick				15. MOTHER'S MAIDEN NAME First Middle Last Carlisle					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes		(If yes give year or dates of service) 1924-1930		16b SOCIAL SECURITY NO 091-09-0257		17. INFORMANT Wife		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coranary Occlusion Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coranary ScleroEis DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hour 5 Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 42									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (I) personally attended the deceased from 7 , 19 48 , to 12 , 19 68 , that (I) (we) last saw the deceased alive on 12-26 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Walter T. Kees				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED <input type="checkbox"/> STAFF <input type="checkbox"/>		22c. DATE SIGNED 12-30-1968			
22d. PHYSICIAN'S NAME (Type) Walter T. Kees				22e. ADDRESS Cockeysville, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 1-3-1969		23c. NAME OF CEMETERY OR CREMATORY XXXXX-2-1968 Arlington Nat'l Cem.		23d LOCATION (City or Town) (County) (State) Arlington, Va.			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson				ADDRESS 1050 York Rd. Towson		25a. REC'D BY REGISTRAR JAN 3 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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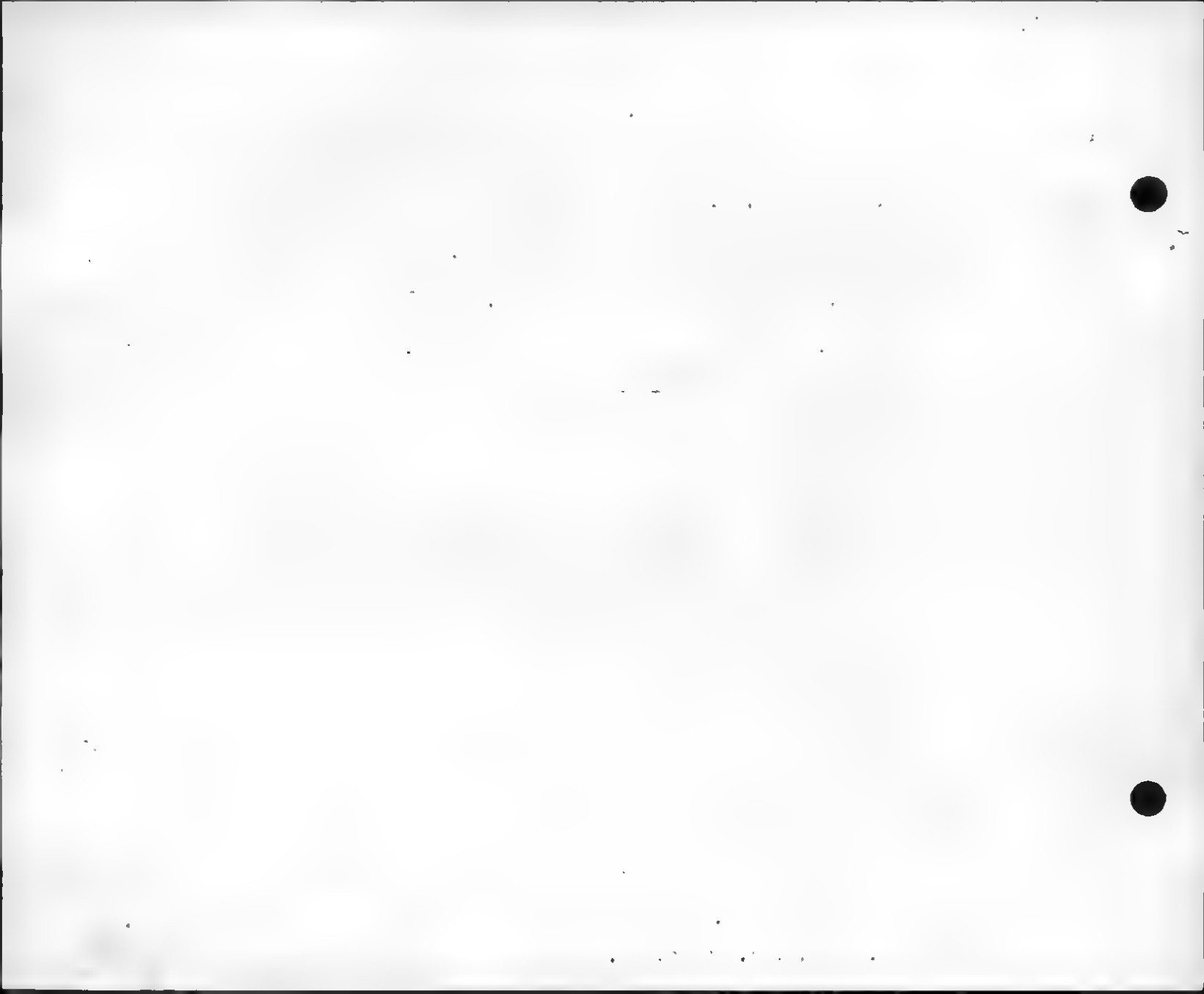
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17112

CERTIFICATE OF DEATH

17152

1 DECEASED NAME (Type or print) Leo		First J.		Middle McDermott		Last		2a DATE OF DEATH Month December Day 26 Year 1968			2b. HOUR 4:40 AM	
3. SEX male		4 RACE white		5 DATE OF BIRTH June 27, 1918			6 AGE (In years last birthday) 50 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md						
10 CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) highway workman			12b KIND OF BUSINESS OR INDUSTRY Balto. City				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b COUNTY Balto.		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1505 Woodbourne Avenue				
14 FATHER'S NAME First Middle Last Albert J. McDermott				15 MOTHER'S MAIDEN NAME First Middle Last Irene Luthhardt								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		(If yes give war or dates of service)		16b SOCIAL SECURITY NO 220-01-6901HA		17 INFORMANT Address Records: SPRING GROVE STATE HOSPITAL						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia 4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Upper respiratory infection. DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Disinfection												
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (a) (this hospital) attended the deceased from Sept. 15, 1967 to Dec. 26, 1968 , that (b) (we) last saw the deceased alive on Dec. 26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.												
22b SIGNATURE Rafael H. Marin, M.D.						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 12-26-68				
22d. PHYSICIAN'S NAME (Type) Rafael H. Marin, M.D.						22e ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 12/28/68.		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery			23d LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				ADDRESS		25a REC'D BY REGISTRAR DEC 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



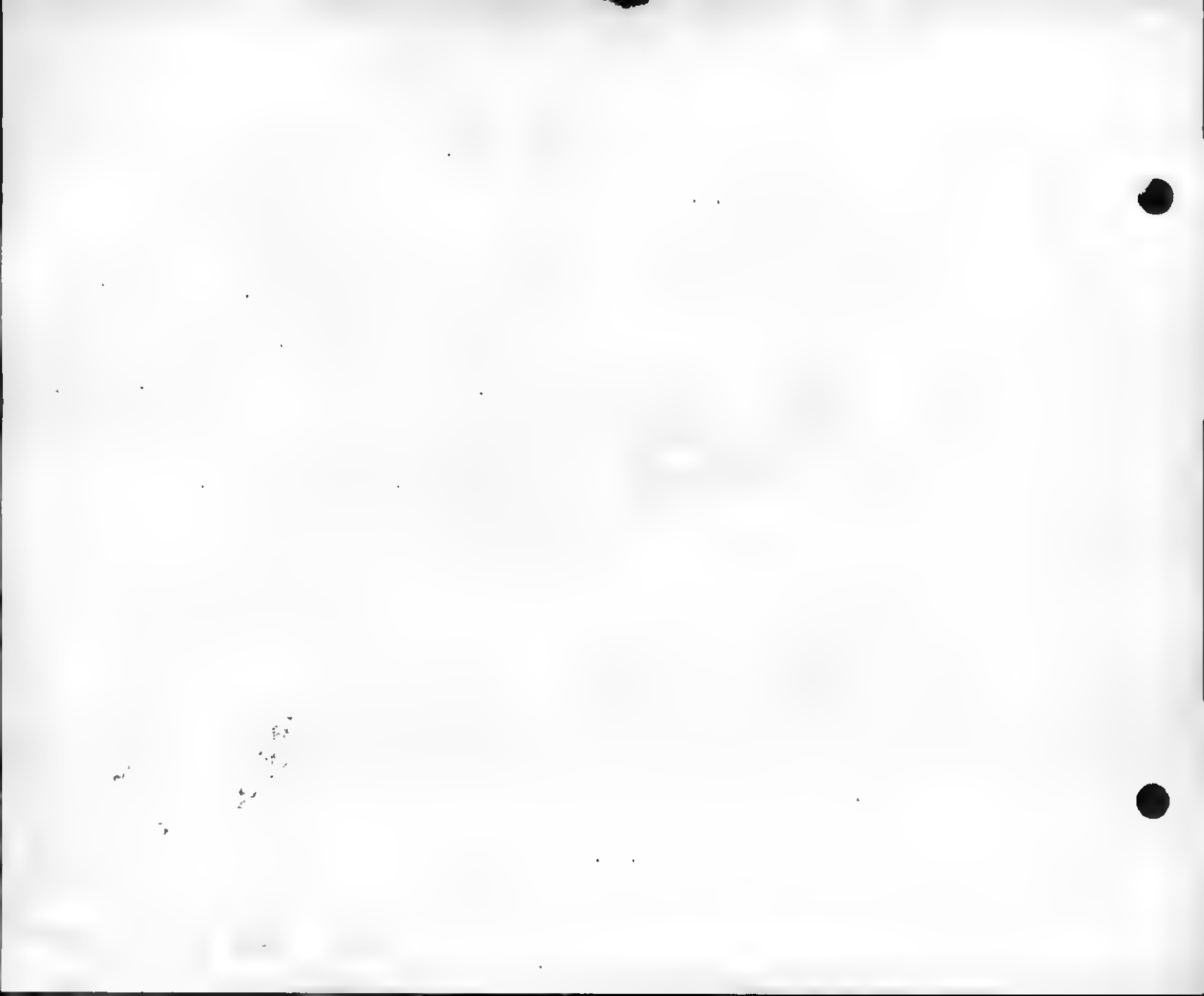
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 45M - 11/1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First WILLIAM		Middle LEO		Last MC DONOUGH		2a. DATE OF DEATH Month 12 Day 4 Year 68		2b. HOUR 10:00AM	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 9/9/97		6 AGE (In years last birthday) 71 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0	
7a BIRTHPLACE (State or foreign) BALTIMORE, MD.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE COUNTY,				Md	
10 CITY OR TOWN OF DEATH FORT HOWARD, MARYLAND		11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp tol give street address) VET. ADM. HOSPITAL		12a U.S.A. OCCUPATION (Kind of work done during most of work on life, even if retired) FILE & MARBLE SETTER		12b K.IND OF BUSINESS OR INDUSTRY CONSTRUCTION					
13a USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admision) STATE MARYLAND		13b COUNTY BALTIMORE		13c CITY OR TOWN BALTIMORE		13d INSIDE CITY L.M.T.P. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 2707 E. Jefferson Street			
4 FATHER'S NAME First WILLIAM		Middle MC DONOUGH		Last HONNORA A. O'MALLEY		15 MOTHER'S MAIDEN NAME First HONNORA A. O'MALLEY		Middle HONNORA A. O'MALLEY		Last HONNORA A. O'MALLEY	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES		(If yes give war or dates of service) WW I		16b SOCIAL SECURITY NO 213 21 22 66		17 INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE, FAR ADVANCED DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH RECENT	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 4											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO AUTOPSY					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No City or Town County State							
22a I certify that (A) (this hospital) attended the deceased from 11/20/68 , 19____, to 12/4/68 , 19____, that (A) (we) last saw the deceased alive on 12/4/68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death											
22b SIGNATURE Erhard J. Bunyor MD		DEGREE MD		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED 12/4/68					
22d PHYSICIAN'S NAME (Type) ERHARD J. BUNYOR, M. D.		22e ADDRESS VAH FORT HOWARD, MARYLAND									
23a BURIAL, CREMAT., OR REMOVA. (Specify) BURIAL		23b DATE 12-7 68		23c. NAME OF CEMETERY OR CREMATORY LOUDEN PARK CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND					
24 FUNERAL DIRECTOR JOHN A MILLER FUNERAL HOME		ADDRESS 2334 E. Jefferson St. Baltimore, Md.		25a REC'D DEC 6 1968		25b REGISTRAR Charles Judge					

MEDICAL CERTIFICATE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

Item 13 Film 407 12/15/68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) First Middle Last <i>Elizabeth K. McGuire</i>						2a DATE OF DEATH Month Day Year <i>Dec. 7, 1968</i>			2b HOUR M		
3 SEX <i>female</i>		4 RACE <i>white</i>		5 DATE OF BIRTH <i>Nov. 13, 1886</i>			6 AGE (In years last birthday) <i>82</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md					
10 CITY OR TOWN OF DEATH <i>Rodgers Forge</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Armcast Nursing Home</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>			13b COUNTY <i>Baltimore</i>			13c CITY OR TOWN <i>Rodgers Forge</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <i>127 W. Glover St. 812, Register Ave. 21221</i>	
14 FATHER'S NAME First Middle Last <i>Uriah Foster</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Not known</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>				16b SOCIAL SECURITY NO <i>2155426179</i>		17 INFORMANT Address <i>Charles W. McGuire 5006 Loch Raven Blv</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>41XC</i> DUE TO, OR AS A CONSEQUENCE OF <i>Generalized Atherosclerosis</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF <i>Cerebral Vascular Disease</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 Days</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 10, 1965</i> to <i>Dec 7, 1968</i> , that (I) (we) last saw the deceased alive on <i>December 7, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>Charles F. O'Donnell</i>						22c DATE SIGNED <i>12/8/68</i>					
22d PHYSICIAN'S NAME (Type) <i>Charles F. O'Donnell</i>						22e ADDRESS <i>7501 York Road Baltimore, Md. 04</i>					
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b DATE <i>12-11-68</i>			23c NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>			23d LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>		
24 FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc Baltimore, Md.</i>						25a REC'D BY REGISTRAR <i>DEC 9 1968</i>			25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

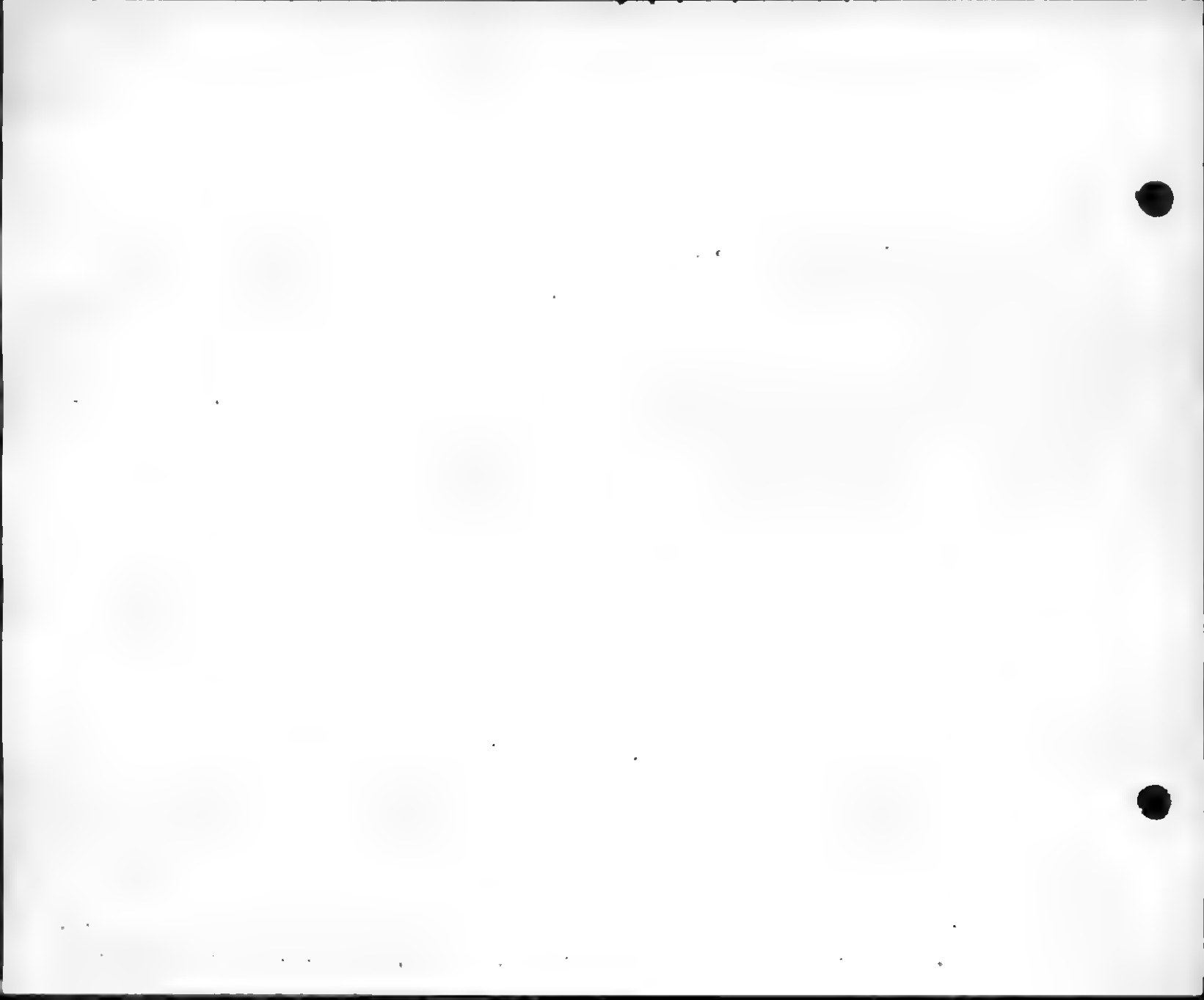


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

<div style="display: flex; justify-content: space-between;"> 17115 MARYLAND STATE DEPARTMENT OF HEALTH 17155 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>											
1 DECEASED NAME (Type or print)			First MARY Middle ANN Last MC PHERSON			2a DATE OF DEATH Month December 21 Day 1968			2b HOUR 8:50 M		
3 SEX Female		4 RACE White		5 DATE OF BIRTH 10-12-19			6 AGE (In years lost birthday) 49 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Georgia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			Md		
10 CITY OR TOWN OF DEATH Baltimore Towson			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d INS-OR CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 14 E. Lake Avenue #21212		
14 FATHER'S NAME First J. Middle R. Last McCalla			15 MOTHER'S MAIDEN NAME First Unknown Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b SOCIAL SECURITY NO. --		17 INFORMANT Edwin McPherson			Address 14 E. Lake Ave., Balto			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic lung disease 5192											
DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12-21, 1968, to 12-21, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12-21-68, 19, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE Ines Cilliani			DEGREE ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 12-21-68					
22d. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D.			22e. ADDRESS 7620 York Road, Towson 4, Md.								
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12-24-68		23c. NAME OF CEMETERY OR CREMATORY Oakhill			23d. LOCATION (City or Town) (County) (State) Newman Ga.			
24 FUNERAL DIRECTOR H.W. Jenkins & Sons Co.			ADDRESS 4905 York Rd., Baltimore			25a REC'D BY REGISTRAR DATE DEC 24 1968			25b REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17116

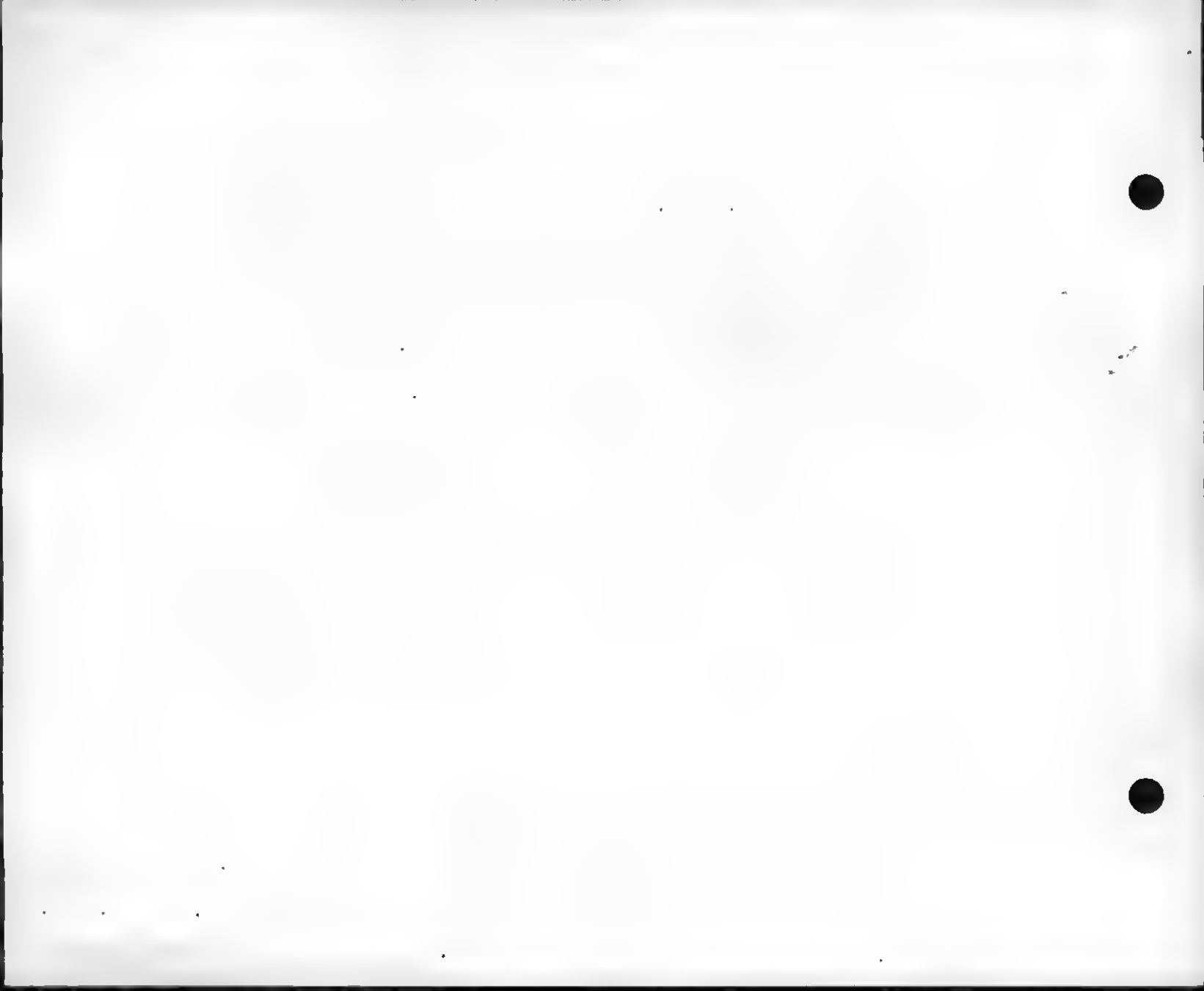
CERTIFICATE OF DEATH

17156

1. DECEASED-NAME (Type or print)		First Alice	Middle Mae	Last Meeks	2a. DATE OF DEATH Month December Day 8 Year 1968		2b. HOUR M
3. SEX F	4. RACE W		5. DATE OF BIRTH April 19, 1880		6. AGE (In years last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Ridgeway Manor		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Housekeeper		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 441 Chalfonte Drive 21228							
14. FATHER'S NAME First Middle Last William Meeks				15. MOTHER'S MAIDEN NAME First Middle Last Eliza R. Wilson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 212-34-8744		17. INFORMANT Address Catonsville Margaret R. Mund #1 441 Chalfonte Drive 21228			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pneumonia 406X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7.15.1							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William Goodman DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED Dec 6			
22d. PHYSICIAN'S NAME (Type) William Goodman				22e. ADDRESS 1334 Sulphur Spring Rd., Baltimore 21227			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-11-68		23c. NAME OF CEMETERY OR CREMATORY Western Cemetery		23d. LOCATION (City or Town) (County) (State) Edmondson ave., Balto. Md.	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue, Balto.				25a. REC'D BY REGISTRAR DEC 11 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

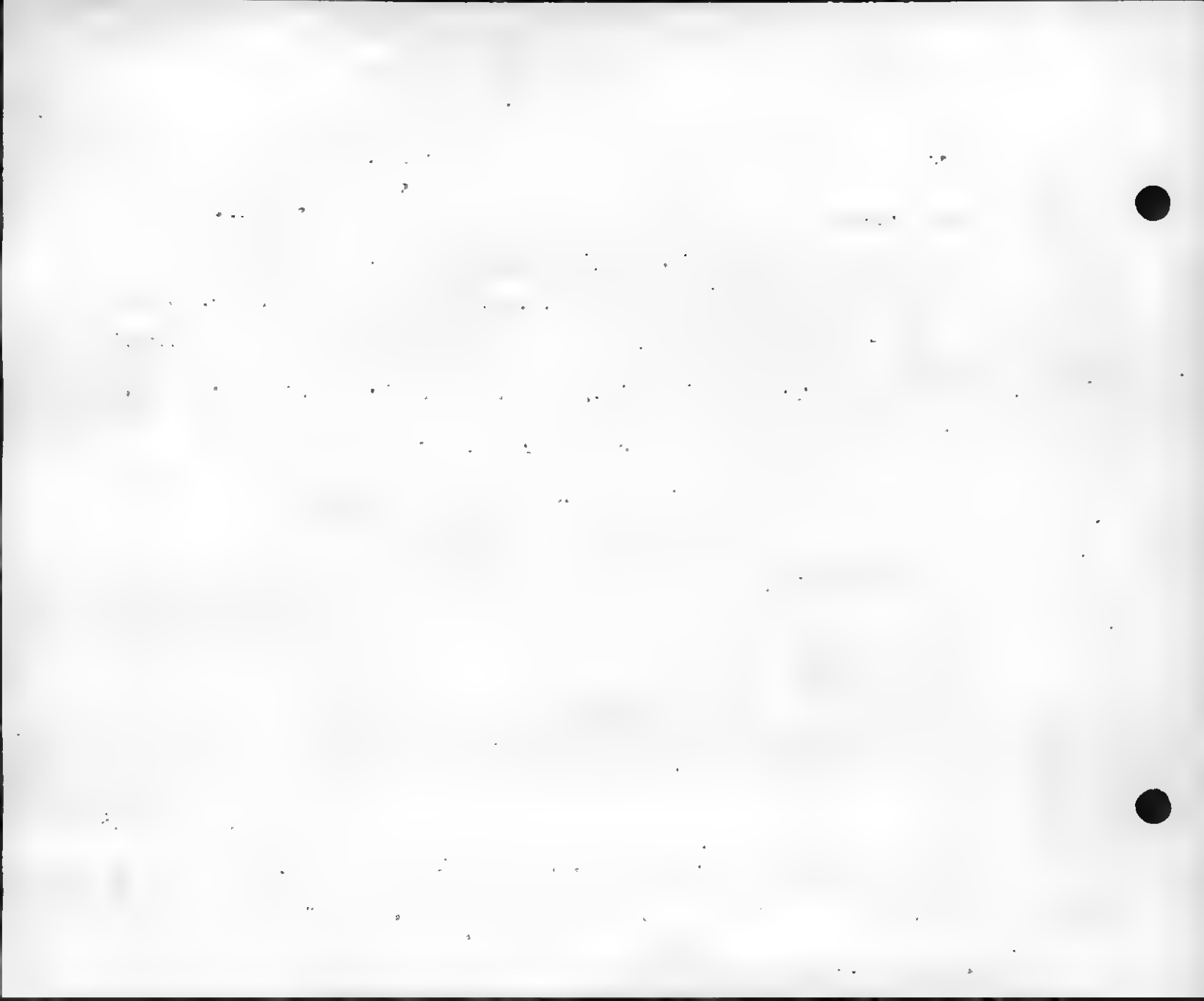


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA R15 (4)
304 REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2c. DATE OF DEATH			2b. HOUR
MATTHEW			H. MEIGHAN			Month Day Year December 5, 1968			PM 11:10
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		2-16-1898		70 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New York		U.S.A.				Baltimore Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson		St. Joseph Hospital		Priest		Redemptorist Fathers			
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
New York				N.Y. City				173 E. 3rd. St. #10009	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last Lawrence Meighan			First Middle Last Catherine Schlitt						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) Yes W.W.II		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
		118-40-8718		Rev. George Rosenkranz		C.S.S.R Same.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>109</u> (b) <u>Severe coronary arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>November 30, 1968</u> , to <u>December 5, 1968</u> , that (I) (we) last saw the deceased alive on <u>December 5, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>ma</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22c. DATE SIGNED 12/6/68	
22d. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.				22e. ADDRESS 7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12-10-68		Mt. St. Alphonsus Cem.		Esopus, New York.			
24. FUNERAL DIRECTOR <u>Charles S. Geiler</u> 901 S. Conkling St. Balto., 21224, Md.				25a. REC'D BY REGISTRAR DATE DEC 9 1968		25b. REGISTRAR'S SIGNATURE <u>Charles S. Geiler</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

17118

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 1 & 2 Film 1/2/69

CERTIFICATE OF DEATH

17158

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>6 mos.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>529 N. Mount Street</u>				d. STREET ADDRESS <u>Forest Haven Nursing Home</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Forest Haven Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>J</u> Last <u>Merrick</u>				4 DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1968</u>			
5 SEX <u>Male</u>		6 COLOR OR RACE <u>Negro</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>9-22-04</u>	
9 AGE (In years last birthday) yrs <u>64</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Editor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newport News, VA</u>		11 BIRTHPLACE (County & State or foreign country) <u>U.S.</u>	
12a. FATHER'S NAME <u>Frank Merrick</u>				12b. MOTHER'S MAIDEN NAME <u>Adeline Mayes</u>			
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW2</u>				14 SOCIAL SECURITY NO. <u>217-01-2644</u>		15. INFORMANT <u>James E. Merrick</u> Address <u>823 W. Salisbury St</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> <u>2509</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>A.C.V.D. - MYOCARDIAL INFARCTION</u> DUE TO (c) <u>DIABETES MELLITUS</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2509</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/24</u> , 19 <u>68</u> , to <u>12/24</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/24</u> , 19 <u>68</u> , and that death occurred at <u>12/24</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>John H. Sullivan</u>				22b. DATE SIGNED <u>12/26/68</u>		22c. PHYSICIAN'S NAME (Type) <u>John H. Sullivan</u>	
22d. ADDRESS <u>5801 Spinnaker Ave. Baltimore</u>				22e. REC'D BY REGISTRAR <u>DEC 27 1968</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>12/27/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bella Halland Cem</u>		23d. LOCATION (City or town) (County) (State) <u>Baltimore MD</u>	
24. FUNERAL DIRECTOR <u>Williams Funeral Home</u>				25a. REG. STRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

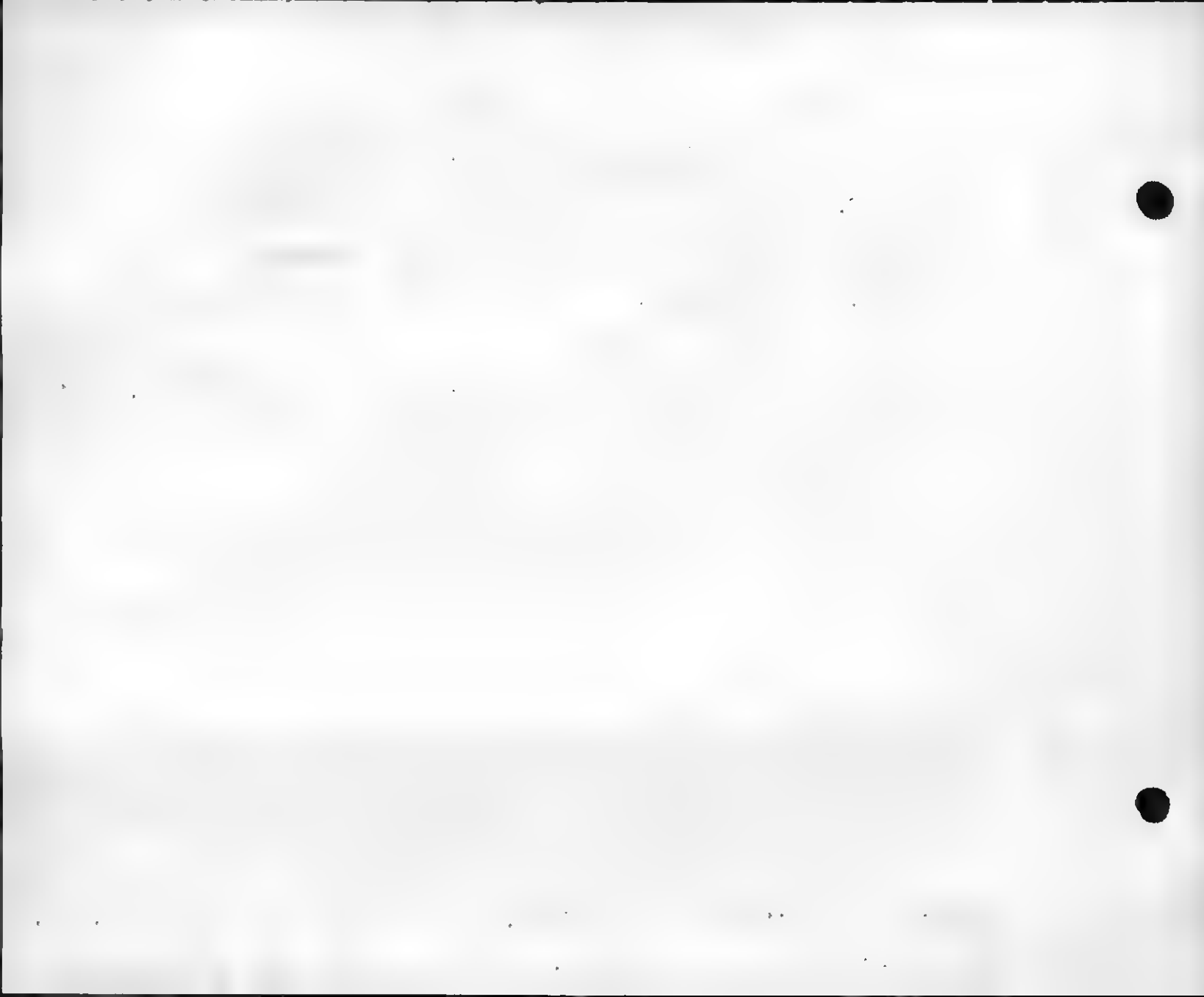
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17149

CERTIFICATE OF DEATH

17159

1. DECEASED NAME (Type or print) First Middle Last Jennie Meyer		2a. DATE OF DEATH Month Day Year Dec. 7, 1968		2b. HOUR 8 A M	
3. SEX female		4. RACE white		5. DATE OF BIRTH Jan. 22, 1882	
7a. BIRTHPLACE (State or foreign country) Balto., Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Baltimore		6. AGE (in years last birthday) 86 YRS		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
10. CITY OR TOWN OF DEATH Rodgers Forge		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 404 Hopkins Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) homemaker	
12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. CITY OR TOWN Balto.	
13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER 404 Hopkins Rd.		13e. CITY OR TOWN	
14. FATHER'S NAME First Middle Last Wolfgang		15. MOTHER'S MAIDEN NAME First Middle Last Jennie Lexstein		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO		17. INFORMANT Address Mrs. Bernice Foard 404 Hopkins Rd. #21212			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 4/127 DUE TO, OR AS A CONSEQUENCE OF apoplexy. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) old age & arteriosclerosis (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4/127					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Nov 1, 1968 to Dec 7, 1968 , that (I) (we) last saw the deceased alive on Dec 7, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. Paul Byers		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-7-68	
22d. PHYSICIAN'S NAME (Type) M Paul Byers		22e. ADDRESS 5820 York Rd			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/11/68		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.	
23d. LOCATION (City or Town) (County) (State) Balto. Md.		24. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home 6500 York Rd. #21212			
25a. REC'D BY REGISTRAR DATE DEC 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

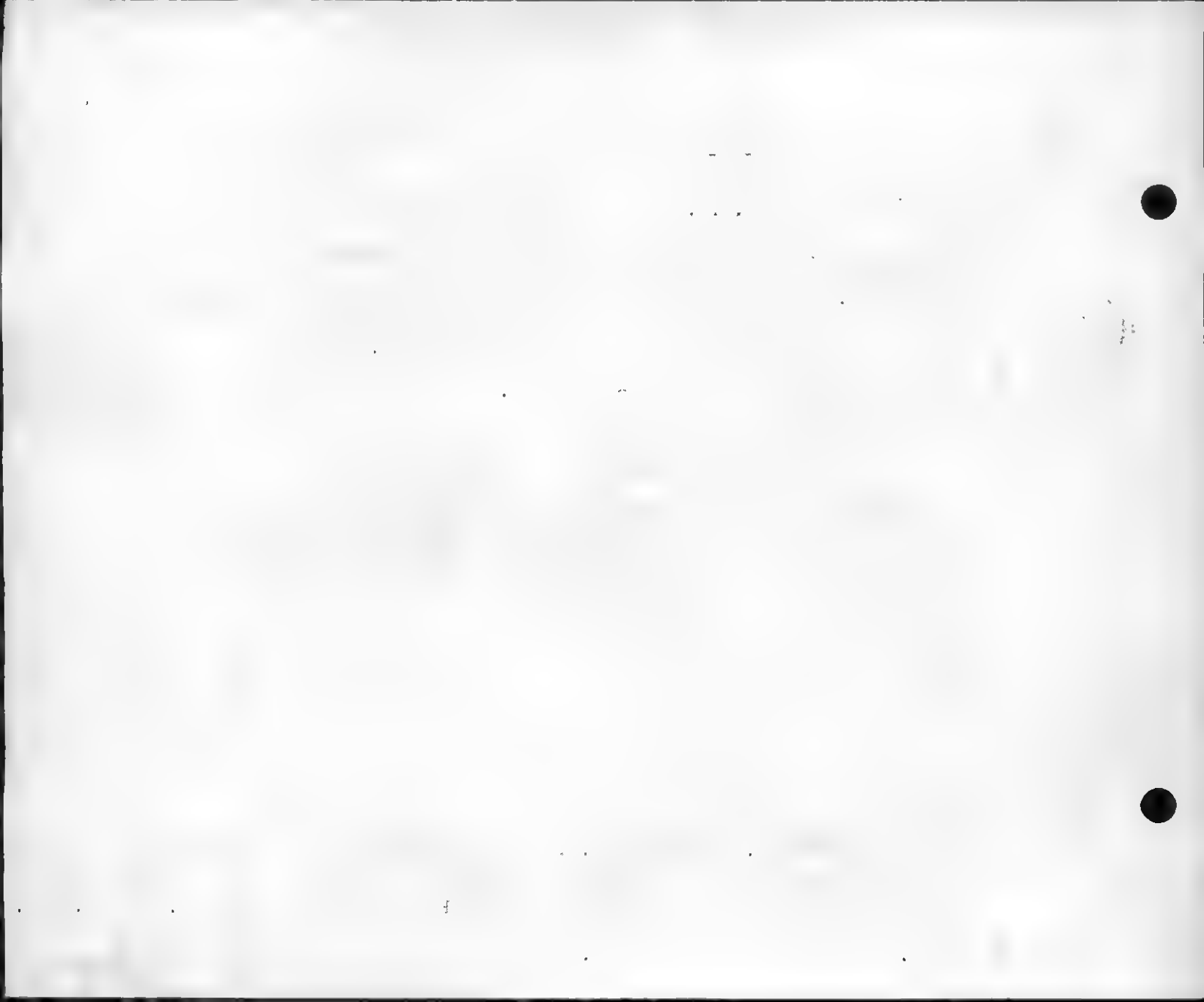
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17150

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17160

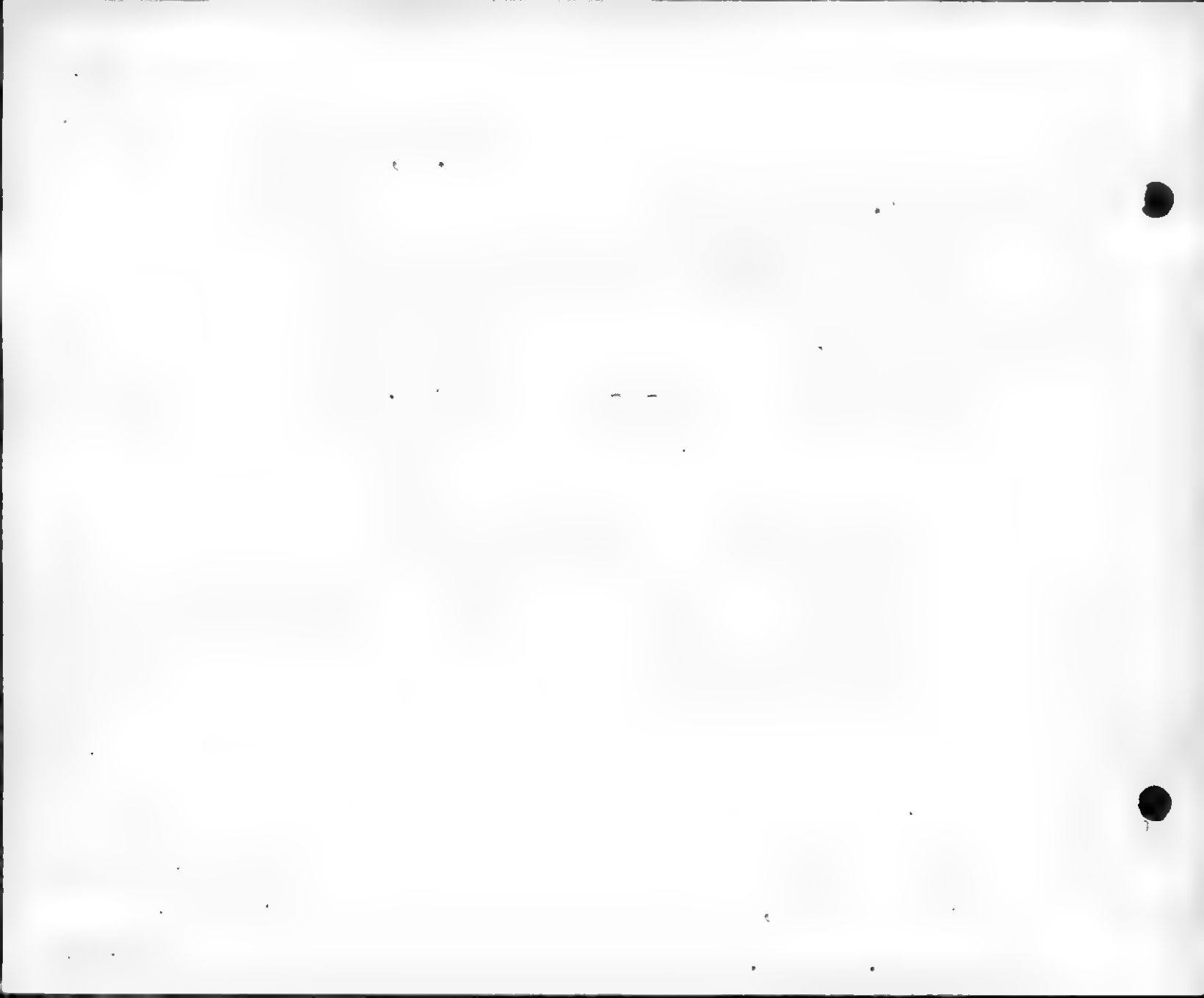
1 DECEASED NAME (Type or Print) WILLIAM		First		Middle		Last MEYER, JR		2a DATE KNOWN <input type="checkbox"/> OF ESTI <input type="checkbox"/> DEATH MATED <input type="checkbox"/> 19		2b HOUR M	
3 SEX Male	4 RACE White	5. DATE OF BIRTH 12--6-07		6 AGE (In years last birthday) 61 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD Month December Day 13 Year 1968		2d HOUR M	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE Md					
10 CITY OR TOWN OF DEATH Dundalk, Maryland		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8221 Watersedge Road				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Packer		2b KIND OF BUSINESS OR INDUSTRY National Can			
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.		13b COUNTY Baltimore		13c CITY OR TOWN Dundalk		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 8221 Waters Edge Road			
14 FATHER'S NAME William Meyer				First		Middle		15 MOTHER'S MAIDEN NAME Emma V. Evers		First Middle Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b SOCIAL SECURITY NO. 214-05-3154		17 INFORMANT ADDRESS Mrs. Emily Wendelstedt, 3435 Dunran Road 21222							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect an <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Springate		EXAMINER'S NAME (Type) Charles S. Springate, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED December 14, 1968	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 12-17-1968		23c NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d LOCATION (City or town) (County) (State) 2901 Taylor Ave., Balto., Md.					
24 FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229				ADDRESS		25a REC'D BY REGISTRAR DEC 17 1968		25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 7 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First Ella		Middle		Last Meynan		2a. DATE OF DEATH Month December		Day 28	
								Year 68		2b. HOUR 4:20	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 18, 1914		6. AGE (In years lost birthday) 54 YRS		IF UNDER 1 YEAR MONTHS 54		IF UNDER 24 HRS HOURS 54	
7a. BIRTHPLACE (State or foreign country) Hurt Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) St. Joseph Hospital				12a. USUAL OCCUPATION (Kind of work done during last year, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2528 Canterbury Rd.-21234			
14. FATHER'S NAME First Samuel Short				Middle				Last			
15. MOTHER'S MAIDEN NAME First Ella Scruggs				Middle				Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 220-03-4060		17. INFORMANT Frederick D. Meynan				Address Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Probably brain hemorrhage 4319 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 131X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, notify medico examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12-27- , 19 68 , to 12-28 , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12-28- , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (we) (a) (did not) view the body after death											
22b. SIGNATURE Christina Feliciano, M.D.		DEGREE		ATTENDING PHYS <input type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/29/68	
22d. PHYSICIAN'S NAME (Type) Christina Feliciano, M.D.		22e. ADDRESS 7620 York Rd., Towson, Md. 21204									
23a. BURIAL, CREMATION (Type) Burial		23b. DATE Jan 2, 1969		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION (City or Town) Baltimore		(County) Maryland		(State)	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Road 21214		ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

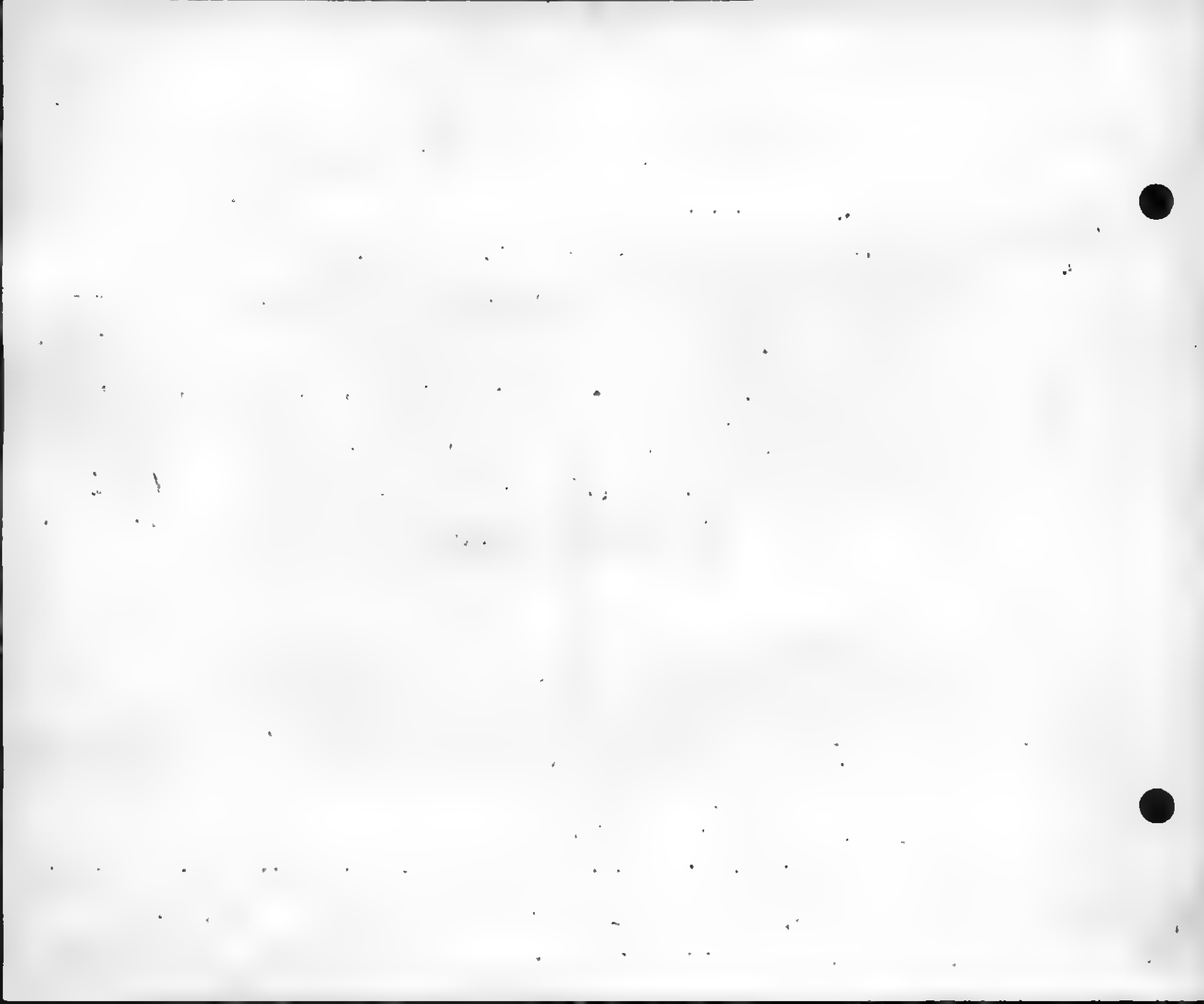


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

17152										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17162									
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
John										MICHAEL										Month 12 Day 8 Year 68 4:05pM									
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (n years last birthday)					7. UNDER YEAR MONTHS					8. UNDER 24 HRS. HOURS M.N.				
Male					White					5-21-14					54 YRS.														
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH														
Maryland					U.S.A.										Baltimore Md														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of work no life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY														
Owings Mills					Rosewood State Hospital					Dependent					none														
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER									
Maryland										Baltimore					YES					128 North Chapel Street									
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																								
Unknown					Anna Michael																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no					16b. SOCIAL SECURITY NO. none					17. INFORMANT Address Rosewood Records, Owings Mills, Maryland																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neuroleptic orthostatic pneumonia</u>															1 hr														
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Carcinoma</u>															1 yr 6 mon														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Carcinoma, bladder</u>															1 yr 6 mon.														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 7/12, 1920, to 12/8, 1968, that (I) (we) last saw the deceased alive on 12/8, 1968, and that in (our) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>Richard A. Jones, M.D.</u> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>															22c. DATE SIGNED 12/10/68														
22d. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.															22e. ADDRESS Rosewood St. Hosp., Owings Mills, Md.														
23a. BURIAL CREMATION, REMOVAL (Specify) Burial					23b. DATE Dec. 11, 1968					23c. NAME OF CEMETERY OR CREMATORY Rosewood Cemetery					23d. LOCATION (City or Town) (County) (State) Owings Mills, Md.														
24. FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md.															25a. REC'D BY REGISTRAR DATE DEC 13 1968					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

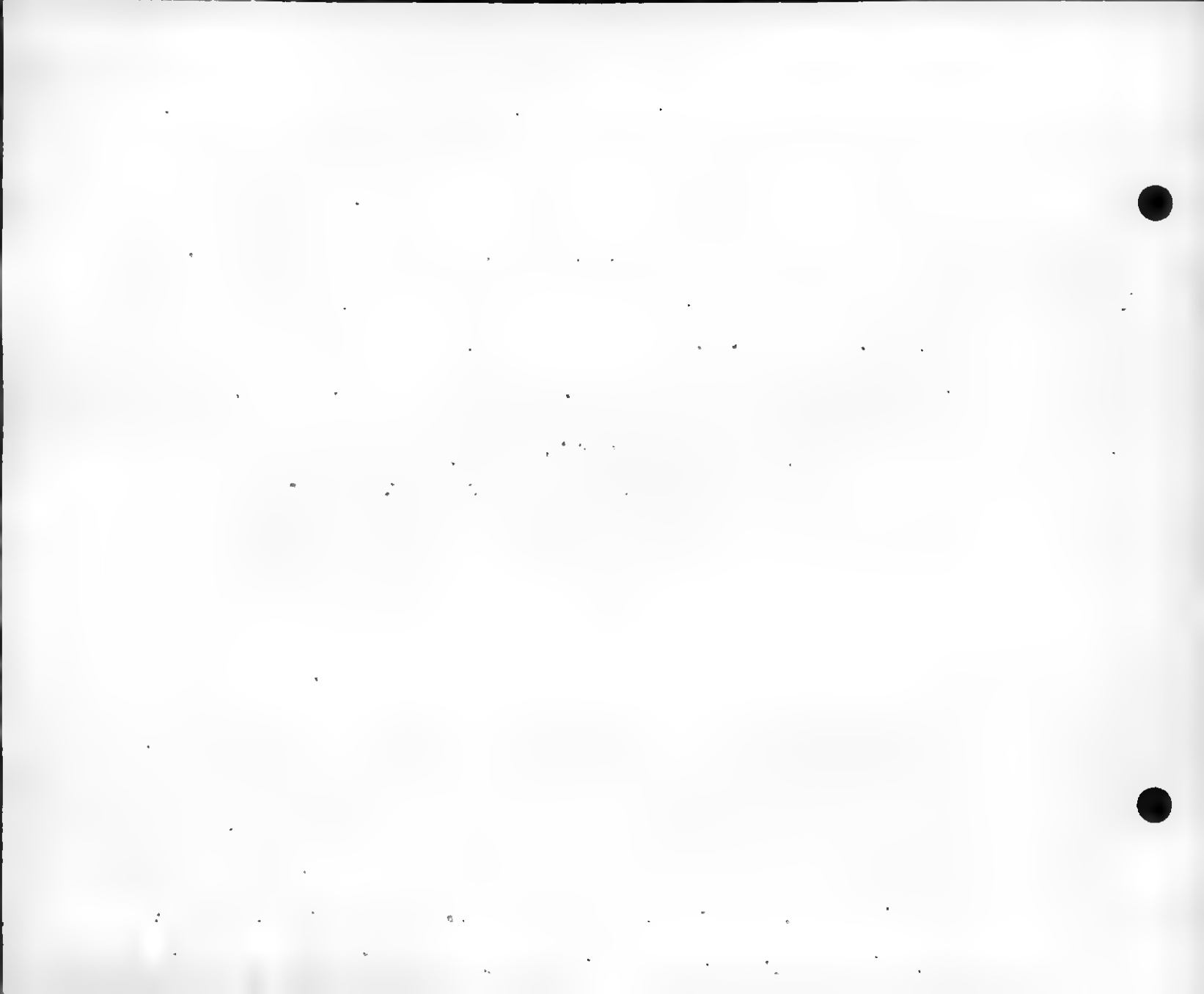


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VA 16 (4)
30M REV 1-68

<div style="display: flex; justify-content: space-between;"> 17153 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17163 </div>											
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR		
<div style="display: flex; justify-content: space-between;"> First Thomas Middle NMN Last MICHALOS </div>						<div style="display: flex; justify-content: space-between;"> 12 Month 26/Day 68 Year </div>			<div style="display: flex; justify-content: space-between;"> 9:35 P M </div>		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Cau		May 17, 1895		73 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Greece		USA				Baltimore					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson			Greater Balto. Med. Center			Restaurant			Self Employed		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Baltimore		Towson				52 Berkshire Road		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
<div style="display: flex; justify-content: space-between;"> First Soterios Middle Michalopoulos Last </div>				<div style="display: flex; justify-content: space-between;"> First Helen Middle Antonopoulos Last </div>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO		17. INFORMANT			Address		
Yes				11703-3307		Steve Micholas, Towson, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Heart Failure											
1369 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) Cerebrovascular accident; RENAL TUMOR?											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 11/9, 1968, to 12/26, 1968, that (I) (we) last saw the deceased alive on 12/26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE								22c. DATE SIGNED			
Barr R. Quillan M.D.								12/27/68			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
						6701 N. Charles Street					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		Dec. 30, 1968		Greek Orthodox Cemetery		Woodlawn, Maryland					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John Burns Sons						JAN 2 1969		Charles Judge			
ADDRESS						Towson					

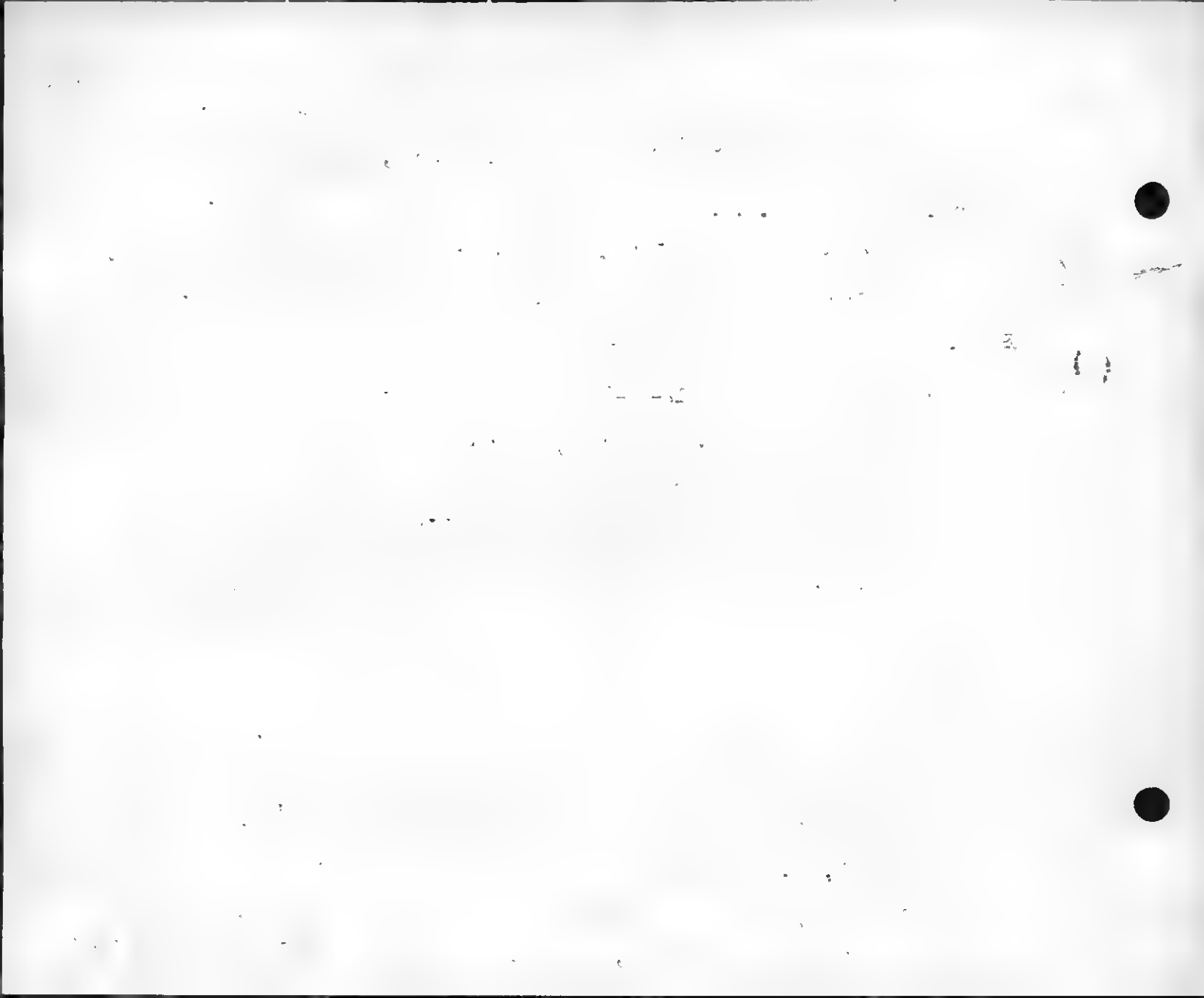


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) ANNA		First ANNA		Middle		Last MILLER		2a. DATE OF DEATH Month DEC. Day 4 Year 1968		2b. HOUR 5 MIN P	
3 SEX FEMALE		4 RACE Caucasian		5 DATE OF BIRTH November 5, 1890		6 AGE (n years most birthday) 78 YRS		7 UNDER 1 YEAR MONTHS 0 DAYS 0		8 UNDER 24 HRS HOURS 0 MIN 0	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE					
10 CITY OR TOWN OF DEATH BALTIMORE		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) GR. BALTO. MED. CENTER		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Supervisor C&P Telephone Co		12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 2907 Glenmore Ave			
14. FATHER'S NAME First Adam Middle Miller Last Miller		15. MOTHER'S MAIDEN NAME First Mary Middle A Last Verges									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 212-03-6566		17 INFORMANT Mrs Marie A Romoser		Address 2907 Glenmore Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPOKALEMIA, AZOTEMIA DUE TO, OR AS A CONSEQUENCE OF RENAL FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: RENAL TUBULAR ACIDOSIS (b) RENAL TUBULAR ACIDOSIS (c) RENAL TUBULAR ACIDOSIS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ATRIAL FIBRILLATION - PNEUMONIA, SEVERE DEHYDRATION, C.V.A.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 12/3 , 19 68 , to 12/4 , 19 68 , that (I) (we) last saw the deceased alive on 12/4 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Enrique A.		DEGREE DR. A. ENRIQUE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/5/68					
22d. PHYSICIAN'S NAME (Type) DR. A. ENRIQUE		22e. ADDRESS 6701 N. CHARLES ST. BALTO. MD 21204									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/9/68		23c. NAME OF CEMETERY OR CREMATORY Oaklawn		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR Leonard J Ruck Inc		ADDRESS Baltimore, Maryland		25a. REC'D BY REGISTRAR DEC 5 1968		25b. REGISTRAR'S SIGNATURE [Signature]					



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VR A15
45M

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR		
RUSSELL			MONDIE			Month 12 Day 17 Year 88		7:00A M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE		NEGRO		8/7/27		41 YRS				
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARR ED <input type="checkbox"/> NEVER MARR'ED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
BALTIMORE, MD.		U.S.A.				BALTIMORE COUNTY,		Md		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
FORT HOWARD			VET. ADM. HOSPITAL			BARTENDER		BAR		
13a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission)			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY, LIMIT?		13e STREET AND NUMBER	
STATE MARYLAND			BALTIMORE		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		226 Chestnut Street	
14 FATHER'S NAME			15 MOTHER'S M A D E N NAME							
First Middle Last			First Middle Last							
MACK			MONDIE			NELLIE MOULTON				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war and dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT Address					
YES			WW II		220-18-8215 CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL										
DUE TO, OR AS A CONSEQUENCE OF (b) LAENNEC'S CIRRHOSIS OF LIVER										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21a INJURY OCCURRED		21b PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f LOCATION		City or Town		County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from 12/8/68, 19, to 12/17/68, 19, that (I) (we) last saw the deceased alive on 12/17/68, 19, and that in (I) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE					22c DATE SIGNED					
RODOLFO G. MIRO, M. D.					12/17/68					
22a PHYSICIAN'S NAME (Type)					22e ADDRESS					
					VAH FORT HOWARD, MARYLAND					
23a BURIAL CREMATON, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)		
BURIAL		12-20-68		BALTO NATIONAL		BALTIMORE, MARYLAND				
24 FUNERAL DIRECTOR					25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
					MORTEN & DYETTE FUNERAL HOME		DEC 20 1968			
					AVONDALE RD. BALTIMORE, MD. 21222					



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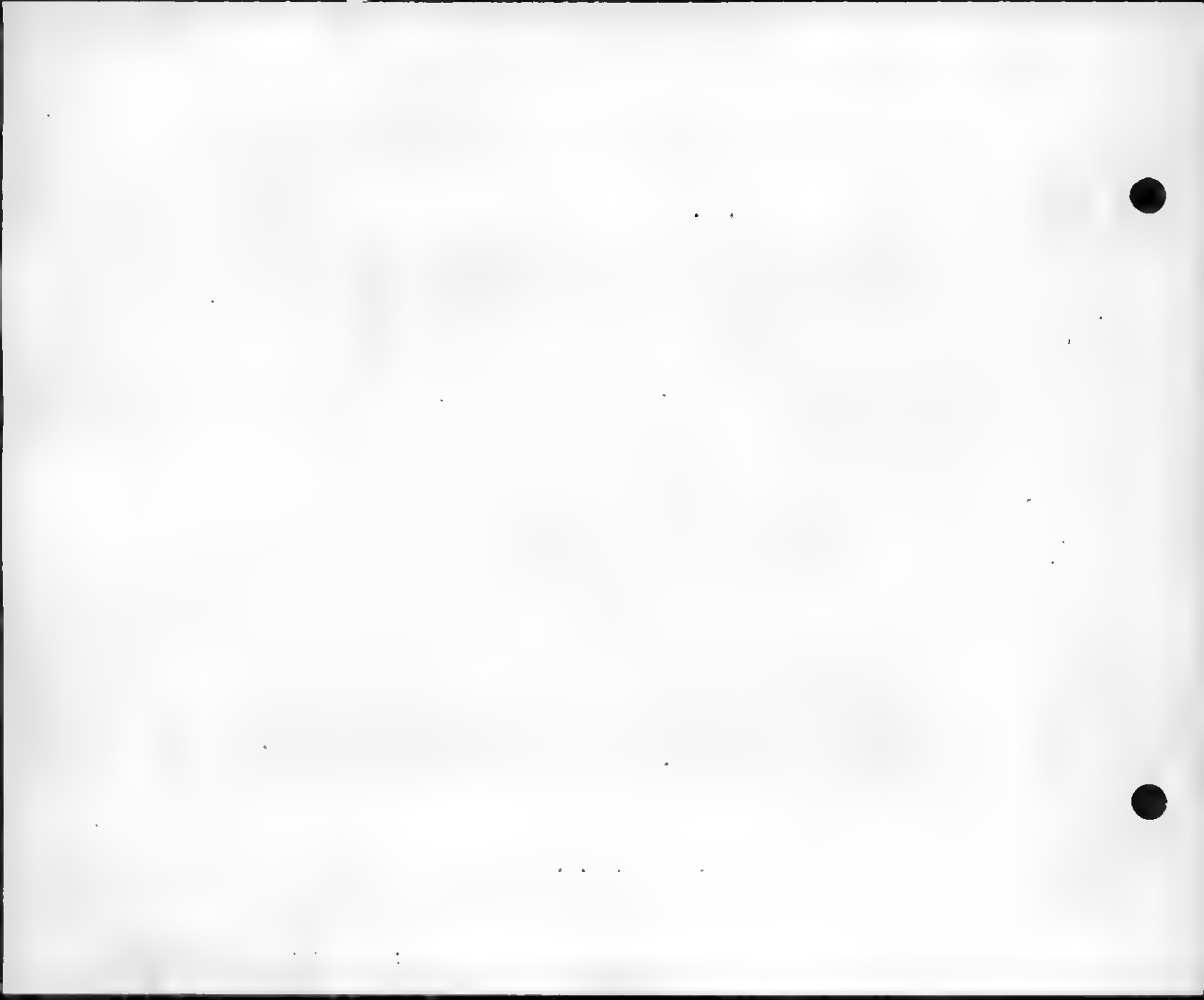
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
17156		17166								
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR		
William			Monroe			12 Month 27 Day 1968		7:10P		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		Negro		8/31/1885		83 YRS.				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U. S.				Baltimore County Md				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Catonsville			Spring Grove State Hospital			laborer				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Prince George		Aguasco		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Aguasco, Maryland	
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Unknown			Winnie Anne Monroe							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT Address					
			213-20-8766A		Chart :SPRING GROVE STATE HOSPITAL					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia										
485X DUE TO, OR AS A CONSEQUENCE OF (b) Upper respiratory infection										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
Arteriosclerotic cardiovascular disease										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (A) (this hospital) attended the deceased from <u>June 5, 19 68</u> to <u>Dec. 27, 19 68</u> , that (A) (we) last saw the deceased alive on <u>Dec. 27, 19 68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b SIGNATURE					DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
<i>Anthony J. Young, M.D.</i>									12-30-68	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
Anthony J. Young, M.D.					SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATED ON (City or Town)		(County) (State)		
Burial		Jan. 4, 1969		St. Phillips Ch. Cem.		Aguasco P. Geo. Co. Md.				
24 FUNERAL DIRECTOR ADDRESS					25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Martell Adams Aquasco, Md.					JAN 9 1969		<i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17167

1. PLACE OF DEATH a COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY ✓	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY in 1b 33 mos.	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d STREET ADDRESS 314 S. Highland Ave	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALFONSO Middle MORECUTTI Last MORECUTTI		4. DATE OF DEATH Month Dec. Day 21 Year 1968	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 4, 1891
9. AGE (In years lost birthday) 77 yrs		10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min 77	
11a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Stone Mason		11b. KIND OF BUSINESS OR INDUSTRY Italy	
12. BIRTHPLACE (County & State or foreign country) Italy		13. CITIZEN OF WHAT COUNTRY? USA	
14. FATHER'S NAME unk		15. MOTHER'S MAIDEN NAME unk	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		17. SOCIAL SECURITY NO. 113-01-6871	
18. INFORMANT Mrs Danelon		Address 314 S. Highland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MULINARY SUSPENSION & ANEMIA 185X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC MALARIA & ANEMIA DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 177 ✓		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/18 , 19 68 , to 12/21 , 19 68 , that (I) (we) last saw the deceased alive on 12/21 , 19 68 , and that death occurred at 11:00 M, from causes and on the date stated above			
22a. SIGNATURE John A. Phaw		22b. DATE SIGNED 12/22/68	
22c. PHYSICIAN'S NAME (Type) John A. Phaw		22d. ADDRESS 1311 Francis Ave	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/23	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	23d. LOCATION (City or town) (County) (State) Baltimore Md
24. FUNERAL DIRECTOR W. J. Zimmerman		25a. REC'D BY REGISTRAR DEC 23 1968	
25b. REGISTRAR'S SIGNATURE John A. Phaw			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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17158

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17168

1 DECEASED NAME (Type or print) <i>Norman Earl Morris</i>			2a DATE OF DEATH Month <i>12</i> Day <i>27</i> Year <i>1968</i>			2b HOUR <i>7</i> MIN <i>45</i>	
3 SEX <i>MALE</i>		4 RACE <i>WHITE</i>		5 DATE OF BIRTH <i>2/26/1903</i>		6 AGE (n years last birthday) <i>65</i> YRS	
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b CIT ZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore County</i> Md	
10 (CITY OR TOWN OF DEATH) <i>Catonsville</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Spring Grove State Hosp</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Planner</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Furniture Shop</i>	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i> COUNTY <i>Baltimore</i>		13b CITY OR TOWN <i>Parkton</i>		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>Bond Road</i>	
14. FATHER'S NAME First <i>George</i> Middle <i>R.</i> Last <i>Morris</i>			15. MOTHER'S MAIDEN NAME First <i>Martha</i> Middle <i>E</i> Last <i>Bond</i>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) <i>No</i> (If yes give war or dates of service)		16b SOCIAL SECURITY NO <i>203-10-4762A</i>		17 INFORMANT Address <i>His wife Mrs. Esther Morris, Parkton, Md</i>			
8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary insufficiency</i> <i>+129</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>Chronic organic brain syndrome</i>							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>8/4/67</i> , 19 <i>67</i> , to <i>12/27</i> , 19 <i>68</i> , that (I) (we) lost the deceased alive on <i>12/27</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>M.A. Lotfizadeh, M.D.</i>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>12-28-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>MOHAMAD A. LOTFIZADEH</i>				22e. ADDRESS <i>Spring Grove State Hospital</i>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>12/30/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Maryland Line Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Maryland, Baltimore, Md.</i>	
24 FUNERAL DIRECTOR <i>James Hartenstein</i>		ADDRESS <i>New Freedom, Pa.</i>		25a RECD BY REGISTRAR DATE <i>DEC 31 1968</i>		25b REGISTRAR'S SIGNATURE <i>John Charles Judge</i>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

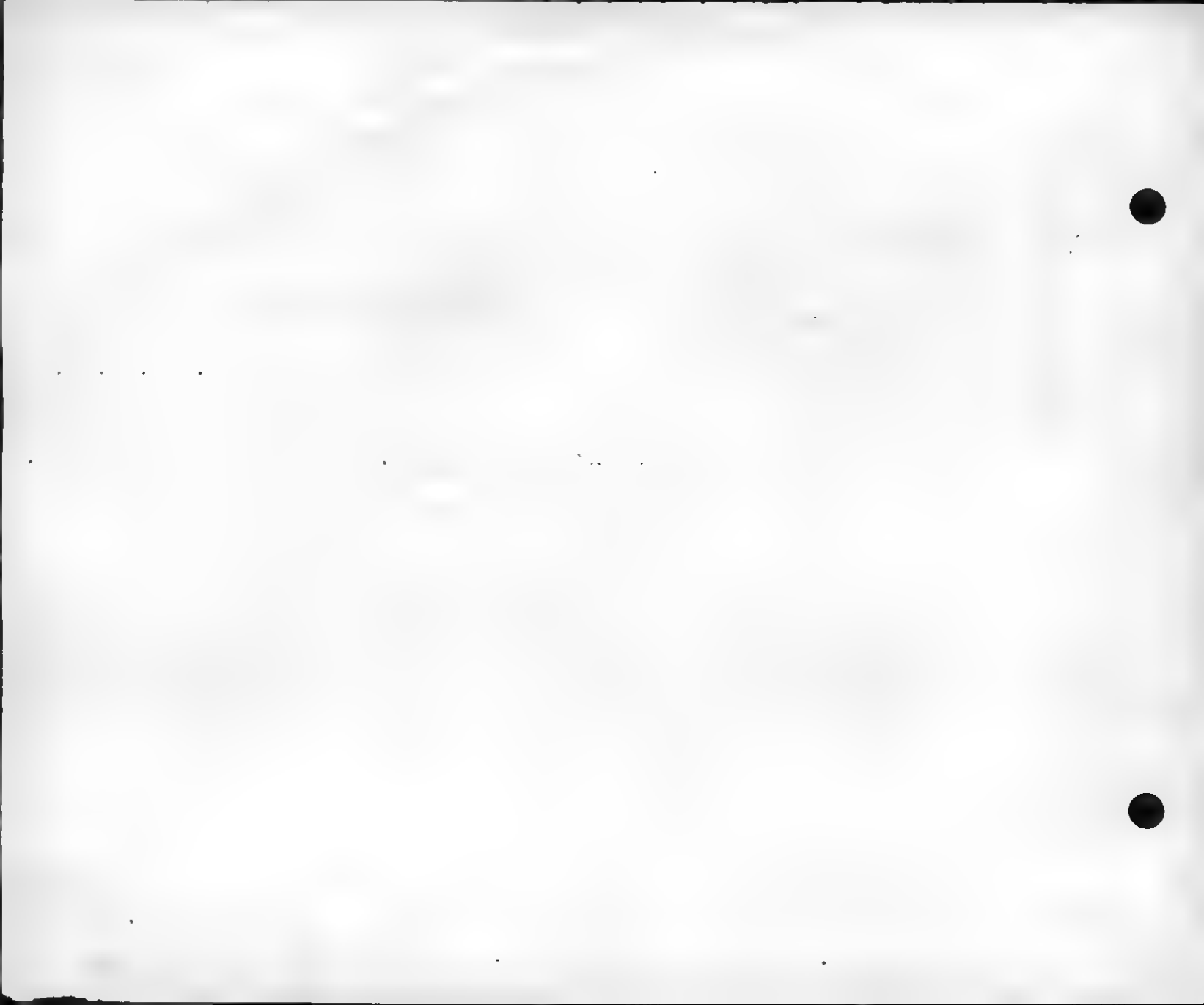
171150

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17169

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY in 1b <u>3 mos. 22 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		d. STREET ADDRESS <u>207 Maple Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Forest Haven Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>MARY ELIZABETH MUMFORD</u>		4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>1968</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>7/14/1913</u> AGE (In years past birthday) <u>55</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State or foreign country) <u>Westminister, Md.</u>
13. FATHER'S NAME <u>Charles Mumfort</u>		14. MOTHER'S MAIDEN NAME <u>Mary Slorpe</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16 SOCIAL SECURITY NO <u>212-18-4901</u>	17 INFORMANT Address <u>Charles E. Mumfort 10 Queen Gate Rd</u>
18 CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> <u>4129</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ACUTE DIARRHEA</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/9</u> , 1968, to <u>12/27</u> , 1968, that (I) (we) last saw the deceased alive on <u>12/27</u> , 1968, and that death occurred at <u>10:28</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John H. Shaw</u>		22b. DATE SIGNED <u>12/28/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN H. SHAW M.D.</u>		22d. ADDRESS <u>5800 EDMONSON AVE. BALDWIN, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/30/1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24 FUNERAL DIRECTOR <u>Raymond C. Fink Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 31 1968</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MIDDLE										LAST										DATE OF DEATH										HOUR																			
1. DECEASED-NAME (Type or print) Catherine										2. DATE OF DEATH Month 12 Day 1 Year 1968										3b. HOUR 10 P M																													
3. SEX Female										4. RACE White										5. DATE OF BIRTH 9/11/1890										6. AGE (In years last birthday) 78 YRS.																			
7a. BIRTHPLACE (State or foreign country) Baltimore										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Baltimore Md.																			
10. CITY OR TOWN OF DEATH Rosedale										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1323 Spring Avenue										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife										12b. KIND OF BUSINESS OR INDUSTRY Homekeeping																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b. COUNTY Baltimore										13c. CITY OR TOWN Rosedale										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER 1323 Spring Avenue									
14. FATHER'S NAME First Middle Last John Bohlen										15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Hawkins										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> None										16b. SOCIAL SECURITY NO. 212 32 1967										17. INFORMANT Marie Walinski 1321 1/2 Spring Avenue									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden																													
4109										DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardio-Vascular disease										5 yrs																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(c) Diabetes Mellitus										4 yrs																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										4201																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 1968, to Dec 30, 1968, that (I) (we) last saw the deceased alive on Dec 30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE G M Baumgardner DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 12/31/68																													
22d. PHYSICIAN'S NAME (Type) G M. BAUMGARDNER										22e. ADDRESS Balto 21237																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 1/2/69										23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery										23d. LOCATION (City or Town) (County) (State) Golden Ring Balto, Md.																			
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road										25a. REGD. BY REGISTRAR DATE JAN 3 1969										25b. REGISTRAR'S SIGNATURE Charles Judge																													

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) Charles		First E.	Middle Myers	Last Myers	2a. DATE OF DEATH Month December Day 25 Year 1968		2b. HOUR 11:15 p. M	
3. SEX male		4. RACE white		5. DATE OF BIRTH July 22, 1896		6. AGE (In years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) painter and paper hanger		12b. KIND OF BUSINESS OR INDUSTRY self employed		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md.		13b. COUNTY Balt		13c. CITY OR TOWN Middle River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1 Cypress Drive
14. FATHER'S NAME First Charles		Middle E	Last Myers	15. MOTHER'S MAIDEN NAME First Ida		Middle Lewis	Last Lewis	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. 485x		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia - 485x DUE TO, OR AS A CONSEQUENCE OF (b) upper respiratory infection DUE TO, OR AS A CONSEQUENCE OF (c) thyroid papilloma - tracheostomy								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 491x since age 2 -								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Dec. 20, 1968 , to Dec. 25, 1968 , that (I) (we) last saw the deceased alive on Dec. 25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b. SIGNATURE Rafael H. Marin		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-26-68		
22d. PHYSICIAN'S NAME (Type) Rafael H. Marin, M. D.		22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-30-68		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Cemetery Md.		23d. LOCATION (City or Town) (County) (State) Baltimore Md.		
24. FUNERAL DIRECTOR Sancti Spiritus Funeral Home		ADDRESS Sancti Spiritus Funeral Home		25a. REC'D BY REGISTRAR 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

1717

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